The Information Search Process in Climacteric Women

by

Carolyn Vogt

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ABSTRACT

The purpose of this study was to describe the information search process in climacteric women. In addition, the socio-demographic characteristics and the attitude toward menopause of women who were searching for information were described.

A comparative, descriptive design was utilized in this study to examine and describe the information search process variables in two groups of climacteric women. The information search process model described and studied by Lenz (1984) provided the conceptual framework for the study. Data were collected from 13 women who registered for the Menopause Information Workshop (MIW) sponsored by the Winnipeg Women's Health Clinic and from nine (9) women who were members of a Winnipeg Nurses' Alumnae (Alumnae). Women from the MIW group were assumed to be in the active phase of the information search process.

Each woman was interviewed using a semi-structured interview format. The Menopause Attitude Scale (Bowles, 1986) and a short questionnaire eliciting socio-demographic characteristics were also completed by each woman. Data were analyzed using content analysis and descriptive statistics.

The findings of the study revealed that some climacteric women were searching actively for information about menopause. Women seeking information were able to identify the information that they wanted or required. Both personal and impersonal sources were used in gathering information. The MIW was

perceived very positively by the women seeking information there. Information that was inadequate or unavailable was seen to be the greatest problem for women when searching for information. An additional problem was the attitude of health care providers toward menopausal women and their experiences. The single most important factor in evaluating the usefulness of information was whether or not the women could relate it to themselves and their experiences. Some of the women in the study did effect some behavioral changes based on information they had found during their search. The women searching for information were younger, peri-menopausal, had a more negative attitude toward menopause, had greater life stress, and more severe menopausal problems than those women who were not searching for information. Those women who were not seeking information said menopause was normal for them, was not posing any problems, and they felt they had access to the necessary information.

An evaluation of the information search process model (Lenz, 1984) was undertaken. Several implications for nursing in the areas of education, practice and research were identified. The study underscores the importance of making available to women adequate information related to menopause.

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Chapter I

STATEMENT OF THE PROBLEM

Historically, women have been socialized to let others, notably males, make decisions for them, to allow others to be in control, and to be dependent on others (Collier, 1982). Women have had a profound lack of knowledge about themselves, their bodies and "treatment" methods for common female conditions (Collier, 1982; Woods, 1982). These factors, in combination with the biases of health care providers and the choice of some women not to participate actively in decisions affecting their health, have had great impact on the health behaviors of women and on the scope and nature of patient education services to promote their health (Collier, 1982; Brown-Bryant, 1985). While some events in a woman's life e.g. childbearing, have received considerable attention in the literature, other events such as the climacteric have been researched much less. The literature tends to emphasize the controversial aspects of the climacteric; few studies have been done to identify the informational or other needs of a woman during this phase of her life. Studies undertaken largely by physicians have focused either on the biological or psychiatric dimensions of the climacteric (Casper & Yen, 1985; Coope, 1983). Menopause has been constructed as a disease with negative connotations.

To date, little scientific data exist on the topic of the menopause and climacteric. The reason for this according to Voda and George (1986) is that much of the menopause research has either design or methodological flaws. For nursing, research about menopause is a fairly recent area of study. The U.S. Report of the Public Health Service Task Force on Women's Health Issues (1985) provides evidence that further scientific knowledge is required. In this report there is a clear call for " a) systematic collection of data about the way the climacteric is experienced by women who are not treated with estrogen and b) research on alternatives to estrogen therapy for treating menopausal symptoms" (p. 94).

The need to address the menopausal experience of women is urgent in that a long post-reproductive phase is now the rule rather than the exception (Lancaster & King, 1985). Since the beginning of the century, the percentage of women over 50 years of age has been rising from about 10% to approximately 30% of the population. Women at age 50 will have a life expectancy of 25 or more additional years. One-third of the female population at any one point in time is living one-third of their entire lives beyond menopause (Swartz, 1984). Clearly an understanding of the menopausal experience from the woman's perspective combined with scientific data would be instrumental in helping women to deal successfully with this developmental stage of their lives. Helping women to deal successfully with the menopausal experience

would assist women in the development of sound health practices and help them to deal with future health concerns.

Nurses in many health care settings have opportunities to identify the health needs of women during the climacteric and to assist them in meeting those health needs. Informational needs are of prime importance and nurses are in a unique position to demystify menopause with concrete knowledge (McPherson, 1981). In order to fill this information gap, nurses themselves must be informed regarding what women want to know about the climacteric and how they want this information provided (Carroll, 1983).

The women's health movement has long advocated that women take an active role in making decisions about their health care and, more latterly, other health care professionals are encouraging this type of behavior (Cox & Roghmann, 1984). Lenz (1984), when developing the active information search model, capitalized on the assumption of the active seeker of health information as opposed to the passive recipient. This model is consistent with the feminist view of health care, whereby women take an active role in making decisions about their health. The extent to which women in the climacteric are actively seeking information is a largely unknown but important area for concern and investigation. For that reason, the purpose of this study was to examine the information search process in climacteric women. The potential benefits of this study to nursing are an increased knowledge of the informational needs of climacteric women, the information search process and how to facilitate

active information searching. The benefits to women are also of considerable import. The "demystification" of knowledge related to health care would empower women to care for themselves and decrease unwarranted dependence on health care professionals (Webster & Lipetz, 1986). From an economic point of view, this could only be an advantage to the health care system. By utilizing practices that promote health and prevent disease, a greater number of women may have less need for contact with the health care system.

Chapter II

REVIEW OF THE LITERATURE

The literature review has focused on pertinent writings found in the disciplines of psychology, sociology, medicine and nursing. Several issues related to women, menopause and the climacteric were apparent in the literature and these are discussed. In addition, relevant research studies are described. Since the focus of this study was not directly related to the physiological aspects of menopause or its cross-cultural aspects, these studies have not been addressed in the literature review. A focus has been maintained predominantly on the research conducted in North America and the United Kingdom.

Attitudes of Society toward Women

The foremost issue arising from the literature review is the attitude of society towards women in general and their health in particular. These attitudes are deeply rooted in history and slow to change. Dunbar et al (1981) and Connors (1985) note that there are great gaps in knowledge relating to the health functioning of women throughout the life cycle, that the majority of the research "on" women is directed toward their childbearing function and that other experiences of women, for example headache and menstrual experience, are largely seen as negative and/or deviant. Health care services, particularly in the view of feminists, are permeated with negative attitudes toward women.

The physician-patient relationship, which is based on a hierarchic model, places the female patient in a subordinate position to the physician (Connors, 1985). Research directed towards females and their health has tended to be "on" women rather than "about" women, that is, women have tended to be the "objects" of study. According to Webb (1984), research has been done by men and non-feminists and as Dunbar (1981) notes, has failed to take into account the experience of women.

Nolan (1986) believes that negative stereotypes of mid-life women continue to exist mainly because of limited research on women in this age group and because of a lack of a female developmental model. A woman is often viewed only in terms of her reproductive role and concomitant vulnerability to hormonal influences. Nolan (1986), however, fails to discuss the powerful impact that advertising, particularly pharmaceutical advertising, has on society's perception of mid-life women. Ford (1986), in discussing this issue, estimates that approximately "$3,000. per doctor per year are spent by the pharmaceutical industry in Canada to convince doctors to buy their products" (p. 14). The advertising used to convince physicians to prescribe medications portrays women as being unable to cope, or dumb, or a nuisance, and menopause is viewed as the end of a woman's useful years. However, the women's health movement which is a blend of consumerism, feminism and self-help is working to change this negative stereotyping of mid-life women by viewing women in a

holistic manner within the context in which they live (Webster & Lipetz, 1986).

Another variable influencing society's attitude towards women is the view, or stereotype, that society has of the mentally healthy person. The mentally healthy man is viewed much differently than his female counterpart. McBride and McBride (1981) note that the "mature, healthy, socially competent woman" is seen as being easily influenced, submissive, emotional and vain regarding her appearance. The mature, socially competent male does not possess these characteristics.

A further stereotype held by society is that changing appearance and depression are common concerns of women in middle age (McBride & McBride, 1981). Berkun (1983) notes, however, that middle-aged women are not the age category of women most vulnerable to depression, and loss of health or spouse rather than loss of physical attractiveness is the real concern. In this case, society's view of middle-aged women is not consistent with real life.

Society has often equated depression with menopause and has perceived that menopause gives rise to depression. In investigating the empirical basis for this perception, McKinlay, McKinlay and Brambilla (1987a) found that only those women who had had a recent surgical menopause (hysterectomy and/or oophorectomy) reported increased rates of depression. In fact, there was no reported depression among the pre-, peri- and post-menopausal groups who were experiencing a natural menopause. The

authors suggest that the findings contradict the widely held view that depression results from menopausally related hormonal changes.

Closely aligned to the attitude of society towards women is the manner in which health care services are utilized by women. For example, women average more visits to the physician than men, take more prescription drugs and utilize considerably more hospital patient days (Marieskind, 1984; Task Force on Women's Health, 1980). While reproductive events in the lives of women explain part of this increased usage of health care services, reproductive events cannot explain the high rate of usage for middle-aged women. A factor which could contribute to this usage is the increased rate of surgery e.g. hysterectomy and oophorectomy, in this age group. This observation was noted by McKinlay, McKinlay, and Brambilla (1987b) who studied utilization of health services associated with menopause and found that women experiencing a surgical menopause were "consistently more frequent users of both formal and informal services before and/or after their surgery" (p. 117). Another factor suggested in the medical literature which contributes to these increased visits is natural menopause. However, Kaufert (1980) discovered in her study that women who were pre- and peri-menopausal had no increase in physician contact although women who were in the advanced post-menopausal group had the highest rate of physician contact. This observation was also supported by Engel (1987) who found that women in her sample (aged 40-55 years) did not use

medications or seek help in relation to menopause although their perceived health status declined as they progressed through menopause. In these instances (Kaufert, 1980; Engel, 1987), one could certainly question whether menopause or the aging process stimulates a visit to the physician or if it is a change in perception of health status. The increased usage of the health care system by women for whatever reason tends to reinforce society's view of women as being neurotic and unhealthy.

In summary, society has tended to view women in a rather negative, stereotypic way (McBride and McBride, 1981). The experiences of women have not always been valued as evidenced in the research that has been done "on" women and the negative view that is held of women's life experiences (Dunbar et al, 1981; Connors, 1985; Ford, 1986). Society has many misconceptions about menopause and mid-life women which are unsupported by the research literature (Berkun, 1983; McKinlay et al, 1987a).

What is the Menopause?

Definition

A key issue in the literature is the definition of menopause, climacteric, pre-, peri-, and post-menopause. A common and literal definition of menopause is simply the cessation of menstruation or the menses. What this simplistic definition does, however, is categorize all non-menstruating women as menopausal regardless of why they stopped menstruating (Kaufert, 1986). Menopause is one event in a process of gradual

decline in ovarian function; this decline is known as the climacteric (Kaufert, 1980). The climacteric precedes and extends beyond the last menses and is comprised of a series of stages, the pre-menopausal, the peri-menopausal and post-menopausal stages (Kaufert, 1980). The definitions of these stages, developed from research about menopause, are based on the assumption of hormonal change as reflected in a woman's menstrual pattern (Kaufert, Gilbert, and Tate, 1987). Women who identify that they are menstruating regularly are defined as pre-menopausal. Peri-menopausal women are those who have menstruated in the last 12 months but not in the last 3 months or whose menstruation has become irregular. A woman is post-menopausal if she has not menstruated in the last 12 months (Kaufert, 1980; Kaufert, Gilbert, and Tate, 1987). In following a group of 324 women who were over 45 and still menstruating, Kaufert, Gilbert, and Tate (1987) found that in a period of three years women did not necessarily progress in an orderly fashion from the pre- to the post-menopause. Some moved back and forth between one stage and another while some became fixed in one particular stage. On the basis of this, the authors recommend that menopausal status not only be viewed as three distinct categories but also as a continuum. The authors also discovered that women rely on their own perception of how their bodies are changing and what is normal or regular for them when assessing their own menopausal status. Kaufert (1982) found in her study that women called themselves menopausal if there had been any change in their usual

pattern of menstruation. Menopause was not perceived as a single event by the women but rather as a process of physiological change over time (Kaufert, 1988).

A wide variety of definitions of menopause and climacteric abound in the literature. For example, some authors (Guebaly, Atchison, Hay, 1984) define menopause as a transition period between the ages of 40 and 55 years which marks the end of a woman's childbearing years. This transition period as defined by Cutick (1984) is called the perimenopause or climacteric. The climacteric as viewed by Nicosia (1987) incorporates the pre-menopausal period, the menopause, and the post-menopausal period during which time a woman moves from a reproductive to a non-reproductive state. Feldman, Voda and Gronseth (1985) differentiate between a menopause transition and a peri-menopausal stage but do not define what the climacteric is and how it relates to the menopause transition and peri-menopause. Voda and George (1986) describe an earlier definition of the peri-menopause that was formulated by Voda wherein the peri-menopausal transition was "an indefinite period of time that begins with the onset of the first hot flash and terminates when hot flashes disappear" (p. 64). This definition contrasts sharply with Kaufert's (1980) definition whereby menstrual pattern is the determinant rather than presence of hot flash. Voda's definition is problematic in that it is culturally bound and based on the assumption that all women experience hot flashes. For example, women in Japan commonly identify shoulder

stiffness as a sign of menopause while hot flashes and night sweats are mentioned infrequently (Lock, Kaufert and Gilbert, 1988).

Determination of menopausal status and the validation of the various terms e.g. menopause, pre-menopause, etc., rely almost solely on self-report of women. Self-report as a means of data collection can be problematic in that the memory of subjects is not always accurate. Colditz et al (1987) found, however, "a high rate of consistency in self-reporting of menopause based on agreement on two questionnaires administered two years apart" (p. 323). They also found high rates of agreement between type of self-reported surgical menopause and actual medical records. These findings may have been influenced by the fact that their subjects were nurses and part of a larger Nurses' Health Study. As well, recall of discrete events such as type of surgery may be somewhat easier than recall of a variety of menopausal changes. In light of this, Kaufert, Gilbert and Hassard (1988) caution researchers to interpret data based on self-report with care as memory may distort the actual changes experienced at menopause.

The issue of definition has much importance for menopause research. If studies are to be compared, the use of identical or similar definitions is essential. For that reason, a group of researchers meeting at Korpilampi, Finland in 1985 reached a consensus for a standard definition of menopause. Natural menopause was defined as "at least 12 months of amenorrhea, not

obviously attributable to other causes" (Kaufert et al, 1986, p. 1286). The Korpilampi group also recognized that women assess their own entry into menopause by other signs than cessation of menses and that the study of how women determine their own menopausal status is important.

In determining menopausal status, what role surgery e.g. hysterectomy and/or bilateral oophorectomy, radiation and/or chemotherapy has played in producing an "artificial" menopause must be determined. Artificial menopause is defined as termination of menses caused by bilateral oophorectomy or as a result of radio- or chemotherapy affecting the ovaries (Kaufert, 1986). Women with hysterectomies experience a natural menopause unless both ovaries have been removed. Their menopausal status, however, cannot be determined on the basis of menstrual pattern (Kaufert, 1986) as they are no longer menstruating.

Not only is it important to use identical terminology in menopausal research but it is also important to separate those women experiencing a natural menopause from those experiencing an artificial menopause. This separation is required if generalizations from the data are to be attempted. The experiences of a woman going through a natural menopause will be different from a woman who suddenly experiences an artificial menopause because of a bilateral oophorectomy. Women who experience hysterectomy without oophorectomy should also be separated from those experiencing a natural menopause as this type of surgery may impact on a woman's experience of menopause.

For example, hysterectomy may precipitate the onset of menopausal changes, such as hot flushes, at an earlier age (Anderson, Barber and Malinak, 1987; Menon et al, 1987).

Another issue is whether to define the menopause as a biological or psychological phenomenon or as a disease process. Many view the menopause and climacteric as a natural biological phenomenon in the reproductive cycle of women (Barbo, 1987; McPherson, 1981). As a biological phenomenon, the climacteric, of which menopause is a part, is a time of gradual decline in ovarian function in which the ovary produces less estrogen, specifically estradiol, during all phases of the menstrual cycle (Barbo, 1987).

As a psychological phenomenon, menopause is seen as a time of psychological loss, loss of one's fertility and loss of children from the home. As Kaufert (1985) points out, this psychological loss is predicated on the importance of children and the mothering role to women. These losses are regarded by some as being responsible for the psychological symptoms e.g. depression, that menopausal women are purported to experience.

While physicians recognize that menopause is a biological event (Casper and Yen, 1985; Wu, 1985), through the years it has been transformed into a disease process. By viewing menopause as an estrogen deficiency disease for which estrogen is the mode of treatment, the medical profession has transformed a biological event into a disease. As MacPherson (1981) notes "This myth of menopause as disease has been so successfully marketed to the

American public that currently most women associate the word menopause with depression if not mental illness, osteoporosis if not cancer" (p.96). Viewing menopause as disease has contributed immeasurably to the "medicalization" of the menopause. MacPherson (1985) is of the opinion that the medicalization of the menopause has been a political achievement rather than a natural outcome of the scientific process in medicine. Medicalization implies that a woman's menopause is closely monitored by a physician and involves the use of Estrogen Replacement Therapy (ERT). According to Kaufert and Gilbert (1986), however, in their study of the menopausal experiences of Manitoba women, this medicalization did not occur to any great extent. They found that "In general, the experience of menopause was not a highly medicalized process and was one in which some women involved their physicians not at all" (p.16).

Rather than viewing the menopause as either a psychological or biological phenomenon or as a disease process, Kaufert et al (1986) suggest that menopause be viewed from a biocultural perspective. This view would incorporate both the biological elements of menopause and the cultural variables operant within a particular environment. Kaufert (1988) further emphasizes the importance of not viewing the menopause as a single event in time but rather as a process over time. Voda and George (1986) also suggest that a different view of menopause be taken. They see menopause as a developmental phase through which all women pass

and they recommend that the "normalcy" of the menopause be documented through research utilizing a feminist perspective.

Symptomatology

The issue of what symptomatology is characteristic of the menopause and climacteric is frequently discussed in the literature. A variety of physical, psychological and psychosomatic symptoms have been reported (Neugarten and Kraines, 1965; Cutick, 1984; Tyler and Woodall, 1982) but not all are substantiated as being characteristic of the menopause or climacteric. The most common physical changes reported are changes in the menstrual cycle, the hot flash or flush and sweats, vaginal changes (dryness and dyspareunia) and later, osteoporotic changes. The relationship of emotional and psychosomatic symptoms, e.g. depression, irritability, rheumatic pains, to the climacteric has not been clearly established (Guebaly, Atchison, Hay, 1984; Cutler and Garcia, 1984; Coope, 1983). As Voda and George (1986) note "Many changes have been reported as being associated with menopausal transition, yet little scientific data exist to support the multiple symptoms attributed to women as they enter and progress through this developmental phase" (p.56).

Perhaps the most obvious and widely recognized symptom of the menopause is the hot flash or flush. A hot flash can briefly be defined as a sudden sensation of excessive bodily heat, with the most intense sensations found in the head, neck and upper trunk areas. Often they are accompanied by profuse perspiration

and a change in skin colour (Cobb, 1988; Swartz, 1984; Voda & Eliasson, 1983). Some authors differentiate between a flush and a flash (Cobb, 1988), a flush simply being a red neck or face without the other characteristics of a flash e.g. intense bodily heat. In an attempt to shed the cloak of misinformation surrounding hot flashes, Feldman, Voda and Gronseth (1985) undertook a study to determine the prevalence of hot flashes among 594 menopausal women. Data were collected over a three month period via a structured telephone interview. Questions related to the subject's perception of menopause, use of estrogen, surgical procedures on the reproductive system, experience of hot flash and at what age first experienced, as well as demographic information.

In analyzing the data, the prevalence rate for hot flash was 88% for the total sample with 45 years as the most frequently reported age when the flashes began. Hot flashes were experienced from one to two years for some women and up to eleven or more years for others. About half of the sample reported a low frequency of hot flashes while the other half reported at least one or more flashes per day. Of the study sample, 42% of the women were currently using ERT. The authors acknowledge that this would have a confounding effect on the frequency of hot flashes. They concluded their report by saying that most North American women can expect hot flashes during their menopausal transition but the frequency and length of years experienced will be highly variable.

The landmark study of Neugarten and Kraines (1965) requires close examination as this study also addresses the issue of what symptomatology is characteristic of the menopause. The purpose of this study was "to provide a wider context in which to view symptomatology against chronological age or developmental events" (p. 267). After pilot testing their menopausal symptom checklist with 100 women, the checklist was administered to over 500 women contacted through high school, YWCA groups, women's clubs, and church groups. The response rate was 85% with women ranging in age from 13 to 65 years. The educational level of the respondents was higher than that of the general population. The symptom checklist included somatic symptoms e.g. hot flushes, psychosomatic symptoms e.g. dizzy spells, and psychologic symptoms e.g. depression. The results indicated that the two groups with the highest number of symptoms were the adolescent and menopausal groups. The symptoms in adolescence, however, tended to be primarily psychological or emotional while those in middle-age tended to be somatic. Post-menopausal women reported the least symptoms of all age groups. A conclusion drawn by the authors was that the exacerbation of the endocrine related changes seemed to be the differentiating factor in symptom reporting, not psychological and social stress.

While Neugarten and Kraines (1965) attempted to determine the "menopausal symptoms" of women in various age groups, Hunter, Battersby and Whitehead (1986) attempted to distinguish menopausal symptoms from those perceived to be psychological or

somatic in a select age group i.e. women aged 45-65 years. To that end, they conducted a cross-sectional survey of a non-menopause clinic sample of volunteers attending an ovarian screening program. The purpose of the study was twofold: "to examine the relationships between psychological, somatic and vasomotor symptoms in pre-, peri- and post-menopausal women; to clarify which symptoms can be attributed to peri- or post-menopausal status and which are best predicted by other factors, e.g. age, psychosocial factors, illness" (Hunter, Battersby & Whitehead, 1986, p. 218).

A questionnaire called the Women's Health Questionnaire was administered to women to collect data on those variables identified in the purpose. Eight hundred and fifty women returned usable questionnaires for a response rate of 78%. Those who were taking estrogen and/or had had a hysterectomy were excluded, yielding a sample size of 682. The mean age of women was 52.3 years; 82% were married and 66% were employed. Eighteen percent were pre-menopausal, 26% were peri-menopausal and 56% post-menopausal.

In analyzing the data, the authors found that depressed mood, vasomotor symptoms, sexual problems and sleep problems increased significantly from pre- to peri- to post-menopause. When prevalence of symptoms was plotted against menopausal status and age, the younger (45-47 years of age) post-menopausal women were found to be the most symptomatic and distressed. The authors also found that in the 45-55 year age range vasomotor and

sexual problems were best predicted by menopausal status; somatic and psychological symptoms by social class; and somatic and anxiety symptoms by absence of employment. A conclusion reached by the authors was that menopausal symptoms cannot be simply attributed to a single variable such as menopausal status or age. In fact, the symptoms attributed to menopause in this study may not be menopausal in origin.

While the study presents some very useful information, generalization of findings to other populations would need to be done carefully as the sample of women was representative only of the population where the study took place i.e. South-East England. Although the sample was from a non-menopause clinic, there was some connection with the health care system as the subjects were volunteers in an ovarian screening program.

One of the major methodological problems in menopause research is the use of samples of menopausal women from clinical settings. In an attempt to overcome this methodological problem, Ballinger (1985) designed a comparative study to determine the levels of psychosocial or life stresses and number of menopausal symptoms in women from the general population and women from a menopause clinic in Sydney, Australia. Her hypothesis was that patients at the clinic would be suffering from more psychosocial stress and symptoms than non-patients. Eighty-eight (88) patients from the menopause clinics completed the Life Events Questionnaire for Middle-aged Women (LEQMW), the Menopause Clinic Health Questionnaire (MCHQ) and the Hamilton Rating Scale for

Depression (HDS). An interview was also done. One hundred and fifty-eight (158) women at shopping centres responded to the same questionnaires and the interview. There were no significant differences between the patient and non-patient groups on education, occupation, partner's occupation, country of origin and marital status.

The results indicated that there were highly significant differences between groups on all measures of stress with clinic patients having the higher mean scores. The total number of life events was also greater for the patient group. They reported significantly more undesirable events and perceived these events as having greater impact than the non-patient group. There were no significant differences between the groups in the occurrence of hot flushes or vaginal atrophy, although the flushes were more severe in the patient group.

Ballinger concluded that women presenting at menopause clinics did suffer significantly more from life stress, psychological symptoms and clinician-rated depression than women in the general population. She adds that these data are consistent with illness behavior in that people with more life stress report more symptoms and tend to seek medical help.

Ballinger's (1985) study is significant from the point of view that menopausal women from clinical settings are demonstrated to be different than menopausal women from non-clinical settings. These differences pertain mainly to stress and life events rather than to physiological changes. Her study

further demonstrates the need to select samples from non-clinical populations in order to obtain a total perspective of the menopausal experience.

Sexual problems and changes in sexual organs are often cited in the literature as being characteristic of menopause and the climacteric. While Leiblum and Swartzman (1986) found female sexuality remained strong following menopause, Sarrel and Whitehead (1985), in an earlier study of women attending a menopause clinic, discovered that loss of sexual desire, loss of clitoral feeling, vaginal dryness and dyspareunia, and the development of secondary non-orgasmic response were significant problems. Sarrel and Whitehead (1985) recognize, however, that 20% of the women coming to the clinic had sexual partners suffering from either sexual, medical or psychiatric problems and that 33 of the 154 women interviewed had long standing sexual problems that developed before the climacteric. The data in this study were collected by a gynecologically trained sexologist using a semi-structured interview. As a result, the potential exists for sexual behaviors to be identified as "problems" that are not seen as such by the respondents. In addition, the women were attending the clinic through a physician's referral because of menopausal symptoms and/or because they wished to have hormone replacement therapy.

A study similar in design to the Sarrel and Whitehead (1985) one was conducted by Bottiglioni and DeAloysio (1982). They concluded that women in the pre-menopause experience a more

fulfilling sex life than those in the post-menopause and that as a woman ages, her sexual activity declines. The study, however, failed to take into account the male partner's sexual activity. As well, all the respondents were volunteers. As a result of the methodological flaws inherent in the Sarrel and Whitehead (1985) and Bottiglioni and DeAloysio (1982) studies, conclusions are difficult to draw.

In an attempt to discover the impact of menopause on sexual behavior in climacteric women, McCoy and Davidson (1985) conducted a longitudinal study of 16 cycling peri-menopausal women. The women recorded their menstrual and sexual behavior daily and were interviewed at four month intervals until a year or more following cessation of menses. At each interview, 20 mL of blood for hormone assays were collected and each woman rated herself for menopausal symptoms and completed a sexuality questionnaire. The findings from the study supported the hypothesis that both sexual interest and coital frequency would decline from pre-to post-menopause. There was also a decline in sexual responsiveness as evidenced in reported need for vaginal lubrication. The data suggested a relationship between breakdown of regular cycling with related hormonal changes and significant decline in sexual activity. McCoy and Davidson recognize the limitations posed by the small sample size and the bias in favour of women with fewer problems at menopause. However, the study does suggest that the physiological aspects of menopause e.g.

lower estrogen levels, may have a negative impact on sexual behavior.

Variables that are thought to impact on menopausal symptomatology are those of age and life stage. The average age when menopause occurs is 50 years, with the exception of some cultural groups (Mahadevan et al, 1982) and this is well documented in the literature (Utian, 1980; Gosden, 1985; Voda and Eliasson, 1983). At 50 years of age a woman is considered to be in her mid-life stage. Traditionally this has been a time when children have left home, aging parents have died and feelings of loss are thought to overwhelm the woman. Not only is there physiological loss in terms of reproductive power and hormonal protection but also in terms of the social end of the mothering role - the "empty nest" syndrome. Caroll (1983) contends, however, that this developmental phenomenon is not limited to women and not necessarily synchronous with menopause. Many couples become parents in their early forties and aging parents often live until their children are senior citizens. To automatically equate the mid-life years with death of parents and loss of children from the home would be incorrect as would identifying these developmental tasks as being responsible for menopausal symptomatology.

In summary, many somatic, psychosomatic and psychological changes have been attributed to menopause but have not been supported by research findings (Voda and George, 1986). Women experiencing increased symptomatology at menopause may be doing

so because of increased stress and greater numbers of undesirable life events (Ballinger, 1985; Hunter et al, 1986).

Medical Management of the Menopause

Since the beginning of the 20th century, the management of women's health matters by physicians has been increasing. What this has meant for the woman in mid-life is increased medical control over the menopausal experience often resulting in use of hormone replacement therapy (HRT) and surgical intervention (hysterectomy and/or oophorectomy).

A debate that surfaces in both the literature and in practice centres on the question "Who really controls the menopausal experience?" As Kaufert (1982) points out, both the medical profession and the women's health movement claim the right to interpret to women their body's experience as a woman. The medical profession's perspective or "medical myth", while describing the menopause as a normal event, focuses on the pathological nature of the menopause and the patienthood of the menopausal woman. The feminist myth, on the other hand, focuses on the naturalness of the menopause while decrying the potentially harmful effects of medical care e.g. ERT. Information sharing among women in relation to their personal experiences with pregnancy, childbirth, or menopause is not encouraged by the medical profession. In sharp contrast to physicians, feminists encourage this sharing of experiential knowledge among women.

The medical profession's actual perspective with regard to menopause was the focus of Lock's (1982) study in which she examined what clinicians do in actual practice and what relationship exists between their working knowledge and written medical texts. Her data were gathered through interviews with 12 gynecologists, 12 family and general practitioners and five residents in obstetrics and gynecology in the Montreal area. She participated in lectures, seminars and clinical rounds on the topic of menopause in three teaching hospitals. Whenever possible she also observed the treatment of menopausal patients in clinical settings. She discovered that medical texts do not "reflect very closely what clinicians actually do" (Lock, 1982, p. 268) and that there was a large degree of variation in the ways menopause was managed. While most of the total group of physicians in the study approached women with a biopsychosocial model in mind, the family and general practitioners tended to be more psychosocially oriented while the gynecologists tended to be more biomedically oriented. Lock recommended that further research be done not only into the relationship of biomedicine to menopausal syndrome but also into the biopsychosocial approach with its "tendency to medicalize the entire life cycle" (1982, p. 277).

The control that physicians exert over women's menopausal experiences will likely increase as physicians continue to determine what role they wish to play in women's health. An examination of the physician role is in direct response to

changing demographics whereby numbers of younger women are declining and numbers of older women increasing. Recently, three well known medical journals devoted 50-100% of one of their issues to the climacteric woman (Barbo, 1987; Speroff, 1988; Notelovitz, 1987). In one article, Speroff (1988) points out that physicians who "interact with women at the time of the menopause have a wonderful opportunity" (p. 37) to provide preventive health care. He sees the future role for obstetricians and gynecologists as managers of women's health care. He further adds that menopause (like pregnancy) serves a useful purpose in that it brings physicians and patients together for the purpose of health maintenance. Notelovitz (1987) also discusses the role of the gynecologist but more specifically in relation to osteoporosis prevention. He believes their role is twofold: informing women about the importance of exercise, nutrition, and lifestyle and prescribing and monitoring HRT. The perceptions that physicians presently hold regarding their role in the medical management of climacteric women will undoubtedly continue to affect the menopausal experience of women who visit physicians.

1. Hormone Replacement Therapy (HRT)

The "management" or "treatment" of the menopause with HRT is a controversial issue not only because it perpetuates the notion of menopause as a deficiency disease but also because of its real and potential side effects. While a form of estrogen was identified and used as early as 1889, its use did not become

prevalent until the early 1960s when exogenous estrogen became widely available (McCrea, 1983). The controversy surrounding the use of estrogen had its beginnings in the mid-sixties when Dr. Robert Wilson's (1966) popular book, Feminine Forever, came on the market. He promised escape from "the horrors of living decay", touting that estrogen therapy would prevent symptoms of aging in women. McCrea (1983) notes that by 1975 estrogen prescriptions reached an all-time high of 26.7 million, making estrogen the fifth most frequently prescribed drug in the U.S. As evidence related to the side effects of estrogen e.g. endometrial cancer, began to appear in the literature in the mid-seventies, the use of estrogen began to decline (Pasley, Standfast and Katz, 1984). In 1981, Pasley, Standfast and Katz (1984) conducted a survey of physicians in 13 counties surrounding Albany and Syracuse, New York to determine how they were prescribing estrogen during the climacteric. A case history of a 51 year old woman was included in a questionnaire sent to 717 physicians (gynecologists, internists, and family practitioners). They were asked how they would treat the woman in 1981 and how they would have treated her in 1974 (The authors recognize the possible bias that was introduced because physicians were asked to recall what they would have done in 1974). A response rate of 81% was received. The woman in the vignette was described as "having frequent, severe hot flashes and other menopausal symptoms" (p. 424). In 1981, 65% of the physicians practicing in both 1974 and 1981 would prescribe

estrogen for the patient; 82% would have prescribed estrogen in 1974. In 1981, 19% of the physicians would prescribe a daily estrogen dose of 1.25 mg. or more for more than six months or .625 mg. daily for three or more years; in 1974, 48% of the physicians would have prescribed estrogen in this way. The conclusion drawn was that physicians had responded to the increasing evidence linking estrogen therapy to endometrial cancer.

Women as well as physicians responded to the information related to the iatrogenic properties of estrogen. Kaufert (1986) found that the women in her study were reluctant to take estrogen because of its association with endometrial cancer and also because of a general fear of hormones. This general fear of hormones was based on their experience with hormones e.g. oral contraceptives, over the past 15 or so years (Kaufert, 1986). While commentary in the literature would suggest that women should be using estrogen, Kaufert found a low rate of estrogen use among peri- and post-menopausal women and a higher rate of use among women with hysterectomies but without oophorectomies. The highest rate of use, however, was found in women with bilateral oophorectomies. In following women who were 45 years of age and over and still menstruating, Kaufert found that in a two year period the percentage of women taking estrogen had increased from 8% at the first interview to 13% at the fourth interview. This increased usage of estrogen is reflective of the changes in the women's menopausal status. What is not evident in

cross-sectional study is the intermittent pattern of estrogen use that was noted over the course of four interviews (Kaufert, 1986).

In response to the risk of endometrial cancer associated with estrogen use, physicians began to prescribe progestins along with estrogen as a protection against the carcinogenic effects of estrogen. This combination of hormone therapy, now considered safe, caused an increase in hormone use once again. For example, use of oral estrogen fell to a low of 14 million in the U.S. in 1980 but by 1983 the number of dispensed prescriptions had increased to 18 million (Ross, Paganini-Hill, Roy, Chao, and Henderson, 1988). Between 1984 and 1985, conjugated equine estrogen moved from 17th to 12th place in a list of 200 of the top drugs prescribed in the U.S. (Ross et al, 1988). Prescription of progestins demonstrated a similar increase. These statistics pertaining to estrogen and progestin use are exclusive of oral contraceptives.

There is evidence in the medical literature of considerable use of HRT as well as considerable pressure for physicians to prescribe HRT to menopausal and post-menopausal women. For example, Ross and his colleagues (1988), in an attempt to determine prescription practices regarding HRT, sent a short questionnaire to 516 gynecologists belonging to the Los Angeles County Obstetrics and Gynecology Society. After two mailings, responses were received from 330 gynecologists for a response rate of 64%. Three hundred and twenty (320) of the 330

respondent physicians (97%) stated they used HRT for at least some of their post-menopausal clients. Three hundred and ten respondents (94%) used estrogen for post-menopausal women with intact uteri; 283 respondents (86%) routinely used a progestin along with the estrogen. For women without uteri, 97% of the gynecologists currently used estrogen with 47% adding a progestin to the estrogen. Ross and his colleagues (1988) concluded, correctly or incorrectly, that HRT was widely used for post-menopausal patients in the Los Angeles area and they predicted a further increase in estrogen/progestin therapy as gynecologists serve as a model for other physicians in the community. This increasing pressure for physicians to prescribe HRT to menopausal and post-menopausal women is also evident in the recommendation put forward by the internists and gynecologists involved with ERT at the Mayo Clinic (Lufkin, Carpenter, Ory, Malkasian, and Edmonson, 1988). They advise "estrogen-progestin replacement therapy as prophylaxis against osteoporosis in all postmenopausal women at high risk for this disorder and for hot flushes, genitourinary symptoms, and changes in mood, in patients who have no contraindications to this therapy" (p. 458). They believe this type of therapy to be safe for women until age 75 years and they encourage women to begin therapy immediately after menopause, whether natural or artificial (Lufkin et al, 1988). The influence on physicians of a group of internists and gynecologists from the prestigious Mayo Clinic would tend to be considerable.

The use of HRT has been and is still a controversial issue (Utian, 1980; Gosden, 1985; Smith, 1987; Ross et al, 1988). The proponents of HRT identify many benefits for the menopausal woman, namely, relief of vasomotor symptoms, prevention of genital atrophy, alleviation of some psychogenic symptoms and protection against coronary artery disease (Budoff, 1987; Gambrell, 1986). However, the major benefit identified is the prevention of osteoporosis (Budoff, 1987; Dobson, 1985; Gambrell, 1986; Walter, 1987). This benefit appears to be the major operational factor in the pressure for physicians to prescribe HRT. Gleit and Graham (1985) note that osteoporosis strikes 15 to 20 million Americans, mostly women, and is characterized by loss of bone mass and porous, brittle bones. Menopause accelerates bone loss and predisposes women to osteoporosis as bone loss occurs whenever estrogen levels drop. In spite of the research conducted, the precise role of estrogen as it relates to bone loss is unclear (Ettinger, 1987; Gleit and Graham, 1985). Regardless of this lack of clarity regarding its role, Ettinger (1987) recommends that women begin taking estrogen at menopause and continuing it for more than ten years. He notes that the longer a woman takes estrogen, the more beneficial it is. Kiel, Felson, Anderson, Wilson, and Moskowitz (1987), in studying hip fracture and estrogen use in post-menopausal women involved in the Framingham Heart Study, found that estrogen use between 65 and 74 years of age "may protect against hip fracture in the subsequent two years" (p. 1172). However, they identify the

difficulty of determining with certainty whether estrogen is protective against hip fracture as the use of estrogen is relatively infrequent in this particular age group. Another difficulty is the long latency period between post-menopausal estrogen use and subsequent hip fracture (Kiel et al, 1987).

MacPherson (1981) believes that by making menopause a syndrome causing osteoporosis, debate over the efficacy of HRT can continue indefinitely. Part of this debate focuses on the economic drain on the health care system of treating elderly women with hip and other fractures that result from osteoporosis (Walter, 1987). However, Weinstein (1980) points out from the findings in his study that HRT is cost-effective only for women with osteoporosis or who have had a hysterectomy, not all mid-life women. The cost of providing medical supervision for women on HRT with intact uteri outweighs the future economic benefits (Weinstein, 1980). While this statement was made some time ago, whether it applies as society enters the 1990s is not known.

The risks to women of using HRT are debated in the literature (Kaufert & McKinlay, 1985) although what constitutes a risk is controversial. For example, Gambrell (1986) describes estrogen as providing protection against coronary artery disease. This effect is achieved through lowering the levels of low density lipo-proteins (LDL), which are viewed as contributing to coronary artery disease, and the raising of high density lipo-protein levels (HDL), which tend to be associated with protection against coronary artery disease. Barrett-Connor, Wingard, and

Criqui (1989) support Gambrell's view on the basis of the data they collected from their study of 1057 women aged 50-79 living in southern California. The original survey was conducted from 1972 through 1974 and repeated from 1984 through 1987 with the same population. They found that users of estrogen had HDL levels that were significantly higher and LDL levels that were significantly lower than non-users. They also found that current estrogen use was associated with lower weight, diastolic blood pressure, and fasting glucose levels. Barrett-Connor and her colleagues (1989) concluded that estrogen should reduce cardiovascular risk. A similar conclusion was reached by Bush et al (1987) in their Lipid Research Clinics Program Follow-up Study. In following a cohort of 2270 white women, aged 40-69 years at baseline, for 8.5 years, they found that women "reporting estrogen use at baseline had a significantly lower risk of cardiovascular death than women not using estrogens" (Bush et al, 1987, p. 1108).

What is often not discussed is the effect that the addition of a progestin has on high-density lipo-proteins, lipo-proteins which tend to be associated with protection against coronary artery disease (Gambrell, 1986). Barrett-Connor (1987) notes that progestin tends to block or reverse the favorable effect of estrogen on low- and high-density lipo-proteins. Bush et al (1987) recognize that their study and the majority of similar studies, examine only the effects of unopposed estrogen rather than the effects of both estrogen and a progestin. In a more

recent study that looked at both opposed and unopposed estrogen use (Barret-Connor et al, 1989), the researchers recognize that the length of time that women have taken estrogen with a progestin is too short to be conclusive. The long term cardiovascular risks and benefits of HRT are largely unknown and continue to be debated. Proponents and opponents of HRT do agree that further research into this area is required (Barrett-Connor et al, 1989; Bush et al, 1987; Whitehead, 1987).

Controversy also revolves around the role of HRT in breast cancer. Gambrell (1986) believes that HRT reduces the risk of breast cancer in women. Barrett-Connor (1987) raises methodological concerns regarding Gambrell's research. She believes his data are inadequate to claim that HRT reduces the risk of breast cancer. In fact, she believes there may be some association between unopposed estrogen use and an increased risk of breast cancer (Barrett-Connor, 1987). Piziak and Shull (1985) maintain there is no evidence to link estrogen with either a risk or protection against breast cancer.

A further complication of HRT may be the increased risk for estrogen users to develop fibrocystic breast disease. Jick, Walker and Jick (1986) found a positive relationship between estrogen use for one year or less and hospitalization for fibrocystic breast disease with the risk for hospitalization increasing substantially with estrogen use over four years duration. Included in this retrospective study were 142 women aged 50-64 years who had been diagnosed by biopsy as having

fibrocystic breast disease and who were using estrogen. The authors recognize the confounding effects that may result from the increased medical supervision which women using estrogen receive. While this study does not conclude that estrogen use causes fibrocystic breast disease, it does raise questions about that particular relationship.

Side effects of HRT that tend to be agreed upon in the literature are increased incidence of gallbladder disease, hypertension, thromboembolic disease, and an increase in the growth of estrogen-responsive cancers already present (Kakar, 1988; Ladewig, 1985; Piziak & Shull, 1985). Side effects which are not often discussed in the literature are those which cause the individual woman noticeable concern or discomfort. For example, estrogen use may cause enlarged and tender breasts, nausea, chloasma, edema, weight gain, headache, and heartburn (Huppert, 1987). With the addition of a progestin to estrogen therapy, women find regular menstrual bleeding to be a problem often resulting in non-compliance with the regimen. Other side effects with progestin include breast tenderness, fluid retention, and depression (Huppert, 1987).

In spite of the controversy surrounding the use of estrogen, there tends to be agreement regarding its use in two particular situations. The first indication is for those women who experience bilateral oophorectomy (Mezrow and Rebar, 1988; Lindsay, 1987). The second indication is for those women who are

at high risk for the development of osteoporosis (Huppert, 1987; Silverberg and Lindsay, 1987).

The benefits, risks and overall efficacy of using HRT have not as yet been decided (Gleit and Graham, 1985; Guinan, Steinberg, and Freni-Titulaer, 1987; Ross et al, 1988). No long-term prospective studies have been conducted to date which demonstrate conclusively the safety and effectiveness of HRT. Considerable debate continues regarding the effect of estrogen and progestin on the lipo-protein profile of women and the overall risk or benefit in terms of cardiovascular health. In the meantime, however, there is considerable pressure in the medical literature for physicians to prescribe HRT to menopausal and post-menopausal women (Lufkin et al, 1988; Ross et al, 1988).

2. Hysterectomy

Hysterectomy is commonly utilized by the medical profession to "manage" menopausal problems related to menstruation. According to Kasper (1985), hysterectomy is the most frequently performed major surgery in the United States. While Manitoba reported a lower rate of hysterectomy in the mid-seventies, the characteristics of hysterectomies (type of hysterectomy, indications for surgery, and size of the hospital where performed) were similar to those done in the United States (Roos, 1984). In the 1987-88 year, the number of hysterectomies performed in Manitoba totalled 2,299 (Manitoba Health Services Commission, March, 1989) compared to approximately 2300 in 1974 (Roos, 1984). While no recent study of hysterectomy rates has

been conducted in Canada, the most current hospital morbidity statistics (Statistics Canada, 1984-85) indicate that, excluding pregnancy and childbirth, other diseases of female genital organs are the leading cause of hospitalization for women in Canada.

Controversy exists over the high rates of hysterectomy and the wide range of indications for performing this surgery. While there is agreement in the literature regarding use of hysterectomy for emergency or life-threatening situations, there are many non-emergency reasons cited for the surgery e.g. varying sizes of fibroids, post-menopausal bleeding, sterilization, to name a few (Anderson et al, 1987; Kasper, 1985). What often occurs simultaneously with hysterectomy is bilateral oophorectomy. Often the rationale for oophorectomy is unclear. For example, Anderson et al (1987) state that "For women who are in their 40s and older and have large fibroids, hysterectomy with bilateral salpingo-oophorectomy is a likely recommendation" (p. 66). The reason they provide is that follow-up for the possibility of ovarian cancer is difficult when the uterus is more than 14 weeks gestational size. However, they do not say why an oophorectomy is indicated. Dicker et al (1982) note in their study that almost 50% of women aged 40 to 44 years had a concurrent bilateral oophorectomy with an abdominal hysterectomy.

While the risk of death from hysterectomy is low, there are a number of complications that can arise, some physiological and some psychological (Easterday et al, 1983). A physiological complication of considerable importance to women is that by

severing the connection between the ovaries and the uterus, ovarian circulation is altered and the life span of the ovaries is decreased by an average of 3-5 years (Anderson et al 1987). Menon et al (1987) found in their survey of 60 women who had undergone simple hysterectomy with preservation of ovaries a high prevalence of menopausal flushes. The mean age of the women at the time of hysterectomy was 35.5 years; the interval between surgery and onset of hot flushes was a median of 2.8 years.

Psychological outcomes of hysterectomy often relate to the meaning the uterus has for women. Gould (1985) discusses the psychoanalytical view of hysterectomy whereby women perceive the uterus and menstruation as signs of femininity and grieve for their loss. Lalinec-Michaud and Engelsmann (1985) point out that many women worry about impairment of sexuality or femininity following hysterectomy. Prior to undergoing hysterectomy, this may create anxiety regarding perceived threats to sexuality and femininity. In a later study, Lalinec-Michaud, Engelsmann, and Marino (1988) found that women experiencing hysterectomy had no greater psychiatric morbidity than women experiencing other types of surgery, although the prospect of hysterectomy caused more stress and immediate depressive morbidity. They also found that women having a hysterectomy without appropriate preparation time experienced greater depressive morbidity. The authors discuss the fact that women need some time to mourn a loss and a threat to the self-concept's integrity. When women in the study were contacted one year following hysterectomy, however, Lalinec-

Michaud et al (1988) found no significant differences between depression scores for women with hysterectomy and women experiencing cholecystectomy and other pelvic surgery.

Kasper (1985) views hysterectomy as an issue of women's health in that women have relinquished some of their power and control over their lives to physicians who claim expertise in the very area that concerns women a great deal, their reproductive/sexual health. By giving physicians this kind of power, Kasper (1985) believes women have left themselves open to decision-making that may not be in harmony with their health and well-being. For this very reason, women's health advocates such as Cobb (1988) are recommending that women obtain a second opinion regarding the need for a hysterectomy.

Summary

The literature points out the confusion that exists regarding terminology related to menopause, both natural and artificial, and the climacteric (Cutick, 1984; Feldman et al, 1985; Guebaly et al, 1984; Kaufert, 1980; Kaufert et al, 1986, Kaufert et al, 1987; Nicosia, 1987; Voda and George, 1986). The issue of terminology and definition holds much importance for menopause research if studies are to be compared (Kaufert et al, 1986). A further issue identified in the literature is whether menopause should be defined as a biological or psychological phenomenon or as a disease process (Barbo, 1987; Kaufert, 1985; MacPherson, 1981). Many physiological and psychological changes have been attributed to the climacteric that have not been

substantiated by scientific data (Voda and George, 1986). The role that life stress plays in the production of symptomatology appears to be substantiated in the literature (Ballinger, 1985; Hunter et al, 1986). Because of its connotation as a deficiency disease, menopause is often managed by the medical profession through the use of HRT. Much controversy is present in the literature related to the risks and benefits to women of HRT (Barrett-Connor, 1987; Budoff, 1987; Gambrell, 1986; Huppert, 1987; Jick et al, 1986; Kakar, 1988; Kaufert and Mckinlay, 1985; Ladewig, 1985; Piziak and Shull, 1985) but to date no long term prospective studies have demonstrated the safety and effectiveness of HRT (Gleit and Graham, 1985; Guinan et al, 1987). In the meantime, there is considerable pressure within the medical profession to prescribe HRT to women (Lufkin et al, 1988; Ross et al, 1988). Hysterectomy and oophorectomy are often performed on women during the climacteric for a variety of reasons (Anderson et al, 1987; Kasper, 1985), reasons that are not always clear to women (Cobb, 1988). This type of surgery may impact on a woman's experience of the menopause in a very negative way (Anderson et al, 1987; Easterday et al, 1983; Menon et al, 1987). Physicians and feminists often hold diametrically opposed views regarding who should exercise control of the menopausal experience (Kaufert, 1982). Physicians tend to medicalize the life cycles of women (Lock, 1982) while feminists encourage women to share information and experiential knowledge. Debate over the control of women's menopausal experiences will

likely continue as physicians respond to the pressure from the medical profession to be managers of women's health care (Notelovitz, 1987; Speroff, 1988).

Attitudes of Women toward Menopause

Central to the whole topic of menopause is how women themselves view menopause and the contextual variables that affect their menopausal experiences. The famous anthropologist, Margaret Mead, saw menopause as an "energetic, creative time in a woman's life" (Voda and Eliasson, 1983, p. 139). Gognalons-Nicolet (1983) sees menopause as a risk and a challenge for women. She further adds that when women approaching menopause were asked what could be the worst thing that could happen to them, more than 50% indicated "losing their husband" while only 4% mentioned menopause.

Loss of fertility and children leaving the home are often implicated as the cause of depression in mid-life women. Kaufert (1985) refutes this argument on the basis of her data from the Manitoba project wherein women were not distressed that they could no longer have children nor were they suffering from an "empty nest" or depression because of an "empty nest". To attribute the problems and concerns (and the satisfaction) of the mid-life to the menopause would be clearly erroneous. Other important social, cultural and developmental forces are obviously involved (Campbell, 1983-84; Gosden, 1985). To assume that menopause and the climacteric is a negative or stressful event is

also erroneous. Griffith (1983) found in her study that older women had fewer stressors and those that they did have were perceived as less important than those of younger women. There is evidence that menopause is an " expected and appropriate" event in the lives of middle-aged women and, if viewed in this way, is not psychologically stressful (Lennon, 1982, p. 353)

In an attempt to determine women's perceptions of non-menopausal and menopausal women and men, Muhlenkamp, Waller and Bouhne (1983) used a vignette approach with 152 middle-class white females between the ages of 18 and 55 years. Represented in the sample were members of community organizations, housewives, college and community college students. Half of the sample received a vignette describing a non-climacteric, middle-aged woman and the other half, a vignette describing a climacteric, middle-aged woman. All received a vignette of a middle-aged male. The vignettes were a relatively neutral description of a middle-aged man and woman. The only change made in the climacteric female vignette was to add the sentence "I think I'm in menopause". Ratings were then done using semantic differential ratings. Subjects also completed the Tennessee Self Concept Scale (TSCS) as a measure of general self-esteem. Results showed that regardless of the age, women in the sample rated other women lower than themselves whether climacteric or not. They also rated the male character lower than themselves, ruling out the devaluing of women by other women as an operant variable. The sample, however, is not a representative one and

no mention is made of the employment status of the subjects. The mean age of the sample group was 37 and although considered to be in the mid-life stage as were the characters in the vignettes, they may have perceived that they were younger than the vignette characters and hence gave a negative evaluation because of the age variable. This possible effect was not discussed in the study. What the authors did suggest was that American women may be ready to reverse the "menopause as disease" concept on the basis that they are no longer differentiating between women in the process of menopause and those who are not. They recommend a similar study to determine the view men have of climacteric versus non-climacteric women as a negative stereotype of women in the climacteric may still exist for men.

Frey (1982) in her study sought "to examine women's perceptions of menopause and their relation to physical symptoms, psychological and socio-cultural variables" (p.25). The instrument used by Frey was the Attitudes-Toward-Menopause questionnaire developed by Bernice Neugarten as well as several questions designed to elicit demographic data. Forty to sixty year old women were surveyed regardless of their menopausal status. None of the respondents were from medical settings but rather were from employment settings, women's groups, workshops, etc. Seventy-eight usable questionnaires were returned. Frey recognizes that the sample was not totally representative in that women in the sample had higher income and educational levels than the general population, were more likely to be employed and of

those employed, were more likely to be in a professional occupation. The sample was representative in the areas of marital status and racial background. The results of the survey indicated that women did not have an illness-orientation toward menopause; those women in professional occupations and with higher educational levels were found to have the highest wellness-orientation. The physical symptom with the highest frequency was fatigue, followed by feeling blue or depressed, forgetfulness, headaches, irritability and nervousness. Thirty percent of the sample were going through menopause at the time of the survey but they did not report a significantly higher frequency of physical symptoms or concerns. Nearly half of the total sample reported no worrisome symptoms at all. From these data, Frey questions the view that menopause is a crisis event or an illness state. Even though women in the sample experienced a number and variety of physical symptoms, they did not view menopause through an illness-orientation.

Building on the work done by Frey (1982), Leiblum and Swartzman (1986) sought to determine the extent to which a sample of generally well-educated and employed women a) regarded the judicious use of hormone replacement, b) believed that the sexuality of peri-and post-menopausal women is impaired, and c) subscribed to a model of menopause as deficiency disease or developmental stage. They also examined the attitudinal differences of the pre-, peri- and post-menopausal women along with the varying educational backgrounds.

The sample consisted of 244 women recruited from continuing education conferences, community education programs, university and medical school staff, volunteers from shopping malls and church/synagogue groups. The mean age was 44.7 years. Of the 85% who were employed, over 47% were employed as professionals while 40% were clerical workers. Seventy-six percent had attended college and/or had obtained a post-graduate degree. The subjects were asked to complete a Menopause Attitude Questionnaire (MAQ) which had been developed by Leiblum and Swartzman and which included some items from Neugarten's Attitude Toward Menopause Questionnaire (ATM).

Results of the survey indicated that 54% believed that menopause should be seen as a medical condition. Women who were older and women who were non-college educated favored the medical model view of menopause. In spite of this, 64% felt that "natural", as opposed to medical, approaches to menopausal problems were preferred. There was no clear consensus on the value of ERT. There was, however, clear consensus that post-menopausal women remain sexually desireable and that female sexuality remains strong subsequent to menopause. In general, respondents attributed psychological difficulties that occurred around the menopause to distressing life events rather than to hormonal imbalances.

The perception women have of menopause as a life event and the timing of that life event were the focus of Lennon's (1982) study. Lennon (1982) asserts that "the psychological

consequences of menopause have yet to be empirically established" (p. 353) although there is much discussion surrounding this topic in the literature. The purpose of Lennon's study was to determine if menopause is psychologically stressful, the hypothesis being that as long as menopause occurs when expected and appropriate, there will not likely be negative psychological consequences for middle-aged women. The data for this study came from a national survey, the Health and Nutrition Survey (HANES), conducted between 1971 and 1975. Respondents ranging in age from 25 to 74 years were interviewed regarding health care needs, socio-demographic characteristics, medical history, nutrition and psychological status as well as examined by a physician. The sample size for this study was 3,742 women. Data were obtained on menopausal status, timing of the menopause and psychological status. The results indicated that the occurrence of menopause at the appropriate time was not related to psychological distress or depression. However, women who experienced menopause "off-schedule" (either early or late) did display significantly greater depression and distress than other females their age. Lennon concludes by saying that, in itself, "menopause does not seem to be psychologically stressful for most women" (p.362). She goes on to stress the importance of the social and cultural contexts in which menopause takes place. She recommends that further research focus on the meaning of menopause to women and how women evaluate its timing in terms of what is expected and normative regarding life events.

In her study of women and their health in the middle years, Kaufert (1981, 1984) examined "issues relating to the health and health behavior of women in the 40-59 age group" (p.279) as perceived by the women themselves. She notes that much has been written in the literature about the impact of menopause on health, especially psychological health, and also about the impact of life events on health. However, these two bodies of literature have not been examined together in any U.S. or Canadian study. Kaufert, along with McKinlay (Jennings, Mazaik and McKinlay, 1984) of Massachusetts, attempted to test hypotheses from these two bodies of literature in their studies. While the Manitoba and Massachusetts studies are different in many respects, they did share some of the questionnaire items and some joint data analysis took place. The Manitoba project was divided into three stages. Stage one was a cross-sectional mail survey. Stage two was a longitudinal study in which approximately 500 women participated over a span of three years. Stage three was a series of semi-structured and in-depth interviews with 100 women taking part in the longitudinal study.

In discussing the data collected from Stage one of the project, Kaufert (1983) found that women in the 40-59 age band were neither overly positive nor overly negative about their own health or the health of other women in the same age group. While many women had experienced one or more physical symptoms in the two weeks preceding the survey, 80% of the women said their health was good or excellent. Twenty percent of the women

reporting one or more physical symptoms had seen their physician during the previous two weeks while 80% had taken some form of medication. Seventy-nine percent of the women had seen a physician at least once during the preceding twelve months, the pap smear test accounting for approximately 20% of the visits. While pre-menopausal women reported fewer health problems and medications taken, there was no difference in the frequency of physician visits or in the use of tranquilizers or sleeping pills. Only the number of physical symptoms reported differentiated the peri-menopausal women from the pre- and post-menopausal women. Regarding fertility, women generally said that they did not want more children and did not regret that decision. As for households being "empty nests", Kaufert found that over half had children at home. The generally prevailing attitude of the women towards menopause was relief that they had had their last menses or no strong feelings of any kind. A small group expressed regret while a rather large number said they had mixed feelings. In concluding her analysis of the data, Kaufert said that it was less the "empty nest" or loss of fertility that distressed women but the realization that they were vulnerable to a loss of their own health or a loss of their relationships.

Instrument development to measure the attitudes of women toward menopause is still very much in its infancy in nursing research. Bowles (1986), however, developed a semantic differential instrument, the Menopause Attitude Scale (MAS), that measures adult women's attitudes toward menopause. In testing

the instrument, a convenience sample of women 18 years of age or older living in Northern Illinois was obtained from church groups, social clubs, hospital volunteer services, etc. The subjects were predominantly white, Catholic or Protestant and employed outside the home. Seventy-five percent had some college education or advanced degrees. Sixty-six percent were pre-menopausal, 6% were menopausal and 28% were post-menopausal. The sample was divided into two groups for testing purposes. Initial pilot testing was carried out using 504 subjects. The second group of 419 subjects was used for validation of the revised instrument. Those subjects who had had a total hysterectomy were excluded as the focus was on natural menopause. The instrument consisted of 45 bipolar adjective scales describing women's feelings and experiences during menopause. Findings from this study indicated that the MAS was, indeed, valid and reliable for the adult female sample studied. It was further corroborated that younger, pre-menopausal women, especially 35 years and under, exhibit more negative feelings toward menopause than women of menopausal or post-menopausal age.

In summary, women are beginning to reverse the concept of "menopause as disease" and recognize that menopause is a "normal" developmental transition in their lives (Frey, 1982; Griffith, 1983; Lennon, 1982). Women in the general population recognize that certain life events are distressing to them but tend not to identify menopause as a stressor (Leiblum and Swartzman, 1986; Lennon, 1982). The "empty nest" syndrome and loss of fertility,

often implicated as being distressful to women, are of less concern than loss of health or a loss of a relationship (Kaufert, 1983; Gognalons-Nicolet, 1983). Younger, pre-menopausal women tend to be more negative about menopause than menopausal and post-menopausal women (Bowles, 1986; Muhlenkamp et al, 1983).

Women's Roles and Life Events - Their Effect on the Menopausal Experience

Various contextual variables related to women's roles and life events can and do have an effect on women's experience of the menopause (Ballinger, 1985; Hunter et al, 1986; Jennings, Mazaik & McKinlay, 1984; Uphold & Susman, 1985; Wheeler, Lee & Loe, 1983; Waldron & Herold, 1986). Women's lives and health needs are constantly changing and must be understood in terms of complicated role combinations (McBride & McBride, 1981). The effect of a woman's work role on her symptoms in the climacteric was studied by Uphold and Susman (1985). In addition to the work role, they examined the child-rearing, marital and recreational roles that many women assume and the effect of these roles on climacteric symptoms. Uphold and Susman (1985) note that the roles women assume have "the potential for providing support or inducing conflict in the lives of midlife women" (p.75). For their study, data were collected from 185 women who were contacted through 16 women's organizations in small, middle class communities in central Pennsylvania. The women completed a demographic data form, the symptom checklist and the Dyadic

Adjustment Scale. In analyzing the data, marital adjustment and an active recreational role were the best predictors of decreased symptomatology in the climacteric. In general, the more roles the women enacted the fewer climacteric symptoms they reported. The authors recognize, however, that their data must be interpreted with caution as the correlation and regression scores were low and the sample an unrepresentative one.

The Massachusetts study (Jennings, Mazaik & McKinlay, 1984), which was an epidemiological study of a general population of women aged 45-54 in that state, had as one of its goals the determination of the relationship between unemployment and health outcomes with the individual woman as the unit of analysis. Women identified from this survey as being pre-menopausal were monitored with a telephone interview every nine months for approximately four years. The first follow-up was completed after nine months on approximately 3,000 women with a response rate of 96%. In analyzing the data related to the first follow-up, unemployed women were found to be the least healthy with full-time homemakers less healthy than employed women. After 27 months of follow-up on this original group of women, those women who were married and had less than 12 years of education tended to be employed in "dull service" or clerical jobs (McKinlay et al, 1987b). These women were more depressed than women who were never married. Women who were never married were typically well educated and/or had stable, career-oriented employment. This group was the least depressed. In this instance, type of

employment would seem to influence health e.g. rates of depression, as would marital status and education.

Nathanson (1980) reported that employed women have higher levels of perceived health than housewives and that they are less likely to engage in illness behavior e.g. physician visits and/or restricted activity days. She also found that women with greater role obligations had less illness behavior e.g. employed women with children at home had fewer restricted activity days than housewives with no children at home. The positive outcome of having numerous roles is supported by Verbrugge (1986) who also found that having numerous roles is associated with good health.

Hibbard and Pope (1985) found that women in jobs with greater social support and integration and women in higher status jobs had better health indicators. Health indicators were measured by a mental health index, self-reported health status, and hospital days. Housewives under forty had better health indicators than women employed in jobs low in social support and integration although this was not statistically significant. On the other hand, housewives over forty had the poorest health indicators while women over forty with jobs high on social support and integration had the best health status measures. Housewives with community involvement had better health status than those not involved in community activities.

Stressful life events at any age can produce psychological distress in both men and women. In mid-life women, however, the menopause is often implicated as the main causative factor of

psychological distress. In light of this, Cooke (1985) undertook the study of stressful life events that produce psychological distress in women and the nature and extent of women's social relationships. Stressful life events e.g. unemployment, were found to precipitate psychological and somatic disturbances. As well, if a women was under significant stress and lacked confidants, her level of psychological distress was increased significantly. Cooke felt that the availability of confidants helped to diffuse the impact of life events and that other professional groups besides general practitioners and gynecologists should be helping with psychological distress. Self-help approaches were also thought to be of value. In concluding, Cooke felt that menopause could no longer be considered the exclusive reason for psychological distress in mid-life as it had been in the past. McKinlay et al (1987b) drew a similar conclusion from their longitudinal study of climacteric women. In following 2500 women for a period of 27 months, they concluded that reported depression was related primarily to "events and situations likely to occur in mid-life but unrelated to the menopause" (p. 358). For example, reported depression in women was likely when a husband or child or both were identified as sources of worry. Ballinger's (1985) conclusions were similar to those of Cooke (1985) and McKinlay et al (1987b) in that women presenting at menopause clinics reported significantly more undesirable life events and perceived these events as having greater impact than like-aged women in the general population.

The marital role, or marital status, exerts a profound effect on both men and women in terms of their health. For example, married women have a higher rate of mental illness than married men, while unmarried women have a lower rate of mental illness than men who are unmarried (McBride & McBride, 1981). Furthermore, mortality rates for non-married persons are higher than for those who are married, with non-married males having a higher rate than non-married females. Hospital use is also found to be higher among the non-married, male and female. While women have a higher rate of hospital use, the rate for married women is less than for non-married men (Morgan, 1980). Women who are widowed, separated or divorced have high rates of depression while never-married women have low rates; married women are between these two extremes (McKinlay et al, 1987b). One could conclude that the marital role has a positive effect on individuals, particularly males.

In summary, the various roles a woman enacts may have an effect on the menopausal experience (Uphold and Susman, 1985). Women with numerous roles tend to have better health than those with fewer roles (Nathanson, 1980; Verbrugge, 1986). Employment, particularly in higher status positions, exerts a positive effect on health indicators (Hibbard and Pope, 1985; Jennings et al, 1984; Nathanson, 1980) as does marriage (McKinlay et al, 1987b; Morgan, 1980). Life events other than menopause e.g. unemployment, can produce psychological distress in mid-life (Ballinger, 1985; Cooke, 1985; McKinlay et al, 1987b).

Information Search and the Menopause

Contemporary society is living in an information age. This growing wealth of information e.g. between 6,000 and 7,000 scientific articles are written daily (Naisbitt, 1982), has considerable impact on society and the individual, particularly in matters of health. The quality of health information, it's availability, and how it is communicated is of particular importance in the health care field as the health of an individual may depend on it. Information has been an integral part of the consumer movement, the feminist movement, and the trend towards self-care in matters of health. How the health care system and health care professionals have addressed the self-care movement and the informational needs of clients, specifically climacteric women, requires examination.

The literature is replete with evidence to substantiate the claim that communication of information, or lack of it, has been and is one of the major sources of dissatisfaction that clients have with the delivery of health care (Shapiro et al, 1983; Messerli et al, 1980; Webb, 1986). In studying the control of information and the exercise of power in the obstetrical encounter, Shapiro and his associates (1983) found that the control of information women might wish to receive rested with the obstetrician. They also found that the "legitimate authority" the obstetrician brings to the obstetrical encounter made it an encounter of two unequal participants. Furthermore,

they discovered that obstetricians greatly underestimated the desire for information reported by their clients.

Similarly, in surveying a group of post-mastectomy women, Messerli and associates (1980) found that most of the women had questions that went unanswered by the surgeons. The women felt that written information prior to surgery would be helpful as would meeting with other mastectomy patients.

Webb (1986), in studying the concept of social support for women undergoing hysterectomy, discovered that information deficit was a predominant theme both pre- and post-operatively. Of particular concern was the fact that lack of information from the hospital staff was the most unsatisfactory aspect of the hysterectomy experience (Webb, 1986). Webb (1986) also found that housewives had less information about hysterectomy than women who were employed possibly because they had less access to social contacts.

Health information regarding menopause has not always been available to climacteric women. In addition, there is little written in the literature describing the information seeking behaviors of climacteric women. Fundamental to information seeking behavior is an understanding of the knowledge level of women in relation to menopause. In 1980, LaRocca and Polit published a study which sought "to determine women's knowledge concerning the menopause and to investigate the relationship between a woman's level of knowledge and her background characteristics" (p.10). Data were collected through a

self-administered questionnaire mailed to 500 women in a medium sized urban community in greater Boston. The community was predominantly working and middle-class. Only females between 40 and 60 years of age were sampled. A response rate of 33.4% yielded 167 usable questionnaires, with most respondents being post-menopausal (n=84). The results indicated a mediocre performance on the test of knowledge (7.1 out of 12) with specific misinformation centering on the age at menopause and the use of physician services for menopausal symptoms. Younger women, women who worked, had a higher educational level or had had an artificial menopause received higher test scores. The majority of the women in this study, especially the younger ones, felt they could talk freely about the menopause with others. The majority of women, both younger and older, believed that most women consult a physician when going through the menopause. The authors recognize that the sample is unrepresentative and not applicable to the general population e.g. rural as well as urban women.

A study similar to LaRocca and Polit's (1980) was conducted by Napholz (1985) to determine working women's knowledge about mid-life health concerns, menopause and health care practices. An exploratory descriptive study for three groups of women from an industrial setting (n=67) was designed. Results of the survey indicated that the women were knowledgeable about mid-life health and could differentiate between menopausal changes and those associated with mid-life. Most felt it was not a "mysterious

phase " of life; the one-third who did, felt they needed more information. Almost two-thirds had discussed mid-life health concerns with someone; one-third had talked with a physician; two-thirds with family and friends. Fifty percent of the respondents rated themselves as having above average health or as being very healthy. The subjects had an average age of 40 and were from a large, midwestern metropolitan area. They were Caucasian, married, employed full-time and had completed high school. As with other studies (Frey, 1982; LaRocca & Polit, 1980), the sample is unrepresentative of the general population and is small in size. In addition, the reliability and validity of the instrument is undocumented. Nonetheless, this study does have important implications for future research into the health of mid-life women, particularly for that portion of women in the study who felt they required more information.

While the studies of LaRocca and Polit (1980) and Napholz (1985) did not address sources of information directly, some reference is made to physicians, friends, and family. Kaufert (1980), on the other hand, inquired about sources of information on the menopause when conducting a pilot study of the health of 200 Manitoban women aged 40-60 years. She found that approximately 50% had been given some or little information by their physician while 83% mentioned magazines and books and 73% friends as sources of information on menopause (Kaufert, 1980). Kaufert (1980) also enquired into the level of support and understanding women received from individuals in their social

environment. Only two-fifths of the women mentioned physicians as providing help and understanding; less than half of the women described their husbands as being helpful and understanding. In general, most of the women in this study felt they could discuss menopause with their physicians, friends or husbands (Kaufert, 1980). Nurses were not mentioned in any of the studies as sources of information on menopause or as sources of support and understanding.

The lack of information which has surrounded health matters of women was instrumental in launching the women's health movement. This movement saw and still views information as power and as a way to empower women to make informed decisions and take control of their lives. An excellent example of this philosophy is the Boston Women's Health Book Collective (1985) whose famous book, Our Bodies, Ourselves, was written to help women understand themselves and their bodies. This growing body of knowledge related to the health matters of women is further evidenced in the work of Janine O'Leary Cobb (1988) whose newsletter, A Friend Indeed, and book, Understanding Menopause, have reached thousands of women. This growth in women's health literature and the networking of women has helped to facilitate the development of alternative health care for women in both Canada and the United States.

This increase in literature pertaining to the menopause has tended to make information more available to women and will undoubtedly affect their general health behaviors. Books written

specifically for women (Budoff, 1984; Cobb, 1988; Neal, 1987; Reitz, 1977; Voda, 1984) emphasize proper nutrition, adequate amounts of exercise, and dealing with psychological stressors. Information related to nutrition encourages women to include sufficient amounts of Calcium and vitamins in their daily diet. Calcium supplements are often recommended but their exact role in preventing osteoporosis is still uncertain and somewhat controversial (Gleit and Graham, 1985). Coffee, tea and alcohol, known to trigger hot flashes/flushes and promote Calcium excretion, are recommended in moderation as is total caloric intake because of a propensity to gain weight with advancing age. Sodium and phosphorus, found in red meats and soft drinks, are thought to increase Calcium excretion and women are encouraged to moderate their intake of them. Weight-bearing exercises are recommended to conserve bone mass and to increase psychological well-being. Women prone to developing osteoporosis are those who are white, thin, nulliparous, sedentary and live in an affluent, Northern country (Cobb, 1988). In relation to psychological stressors, women are encouraged to be accepting of themselves and their feelings, to change the stressors that they can, and to learn to relax and enjoy themselves more. Content related to the use of HRT is also present in these books and may provide women with some measure of confusion because of the opposite views on hormone use. For example, Budoff (1984) believes that "proper" HRT will be the norm of the future, not only saving lives but improving the quality of women's lives. Other authors take a

more cautious approach to estrogen use, pointing out the risks to women of that use (Cobb, 1988; Neal, 1987; Voda, 1984). What effect health information such as this has on the health behaviors of menopausal women is largely unknown. What is also unknown is how available this health information is to the "average" woman who is in her climacteric.

In summary, communication of information, or lack of it, is a major source of dissatisfaction to clients in the traditional health care system (Messerli et al, 1980; Shapiro et al, 1983; Webb, 1986). Because of this, women have found alternative means of obtaining information about their health in general and menopause in particular (Boston Women's Health Book Collective, 1985; Cobb, 1988). While women are becoming more knowledgeable about menopause and mid-life health (LaRocca and Polit, 1980; Napholz, 1985), there still are groups of women who require more information. In addition, very little is known about the ways in which women search for information on the menopause.

Role of the Nurse and the Climacteric Woman

Nurses have a role to play in assisting women to deal with health concerns related to the climacteric. Wilson (1979) is of the opinion that women are receptive to "interventions which promote growth and change" (p. 26) when they enter the health care system. At times such as this, nurses must focus on the individuality of women and assess if women are searching for information on the menopause and if they are, determine their

particular needs for information on the menopause. As Wilson (1979) points out "Nurses are in key positions to work with women in the health care context with the goal of increasing their sense of self-esteem and ability to solve problems" (p. 29).

While nurses have some measure of control over the manner in which they meet the nursing needs of menopausal women, often their control is limited in relation to influencing the larger health care scene. The reason for this is that only a small minority of women are actually in management positions within the health care system even though the majority of health care workers are female. Given this underrepresentation of women in management positions, women experience difficulties in influencing decisions that are made at that level. For example, the fiscal resources necessary to provide for the health care needs of menopausal women may not be allocated because of a lack of understanding regarding those needs.

Nurses can, however, effect change in many ways as they have important roles to play in the areas of theory development, research, education and practice as it relates to the health of women in general and menopausal women in particular. Webster and Lipetz (1986) discuss the importance of nursing theory addressing the "particular experiences of women as distinct from those of men" (p. 91). In carrying out nursing research, Woods (1982) challenges nurses to address women's health from three dimensions. The first dimension should include the developmental stage of a woman's life, incorporating biological, cognitive,

social and affective aspects of development. The second dimension should address the various contexts for women's health e.g. social systems and the biophysical environment. Health variables comprise the third dimension and pertain to health concerns, health problems, and health-seeking and health-damaging behaviors. As nurse researchers in the area of women's health, Webster and Lipetz (1986) stress the importance of using non-sexist language and treating the experiences of the subjects as being valuable. Nursing education content should be focusing on concepts identified from women's health research, emphasizing the importance of the lived experience and the dimensions identified by Woods (1982). Teaching-learning strategies utilized in nursing education should address how both men and women learn. Webster and Lipetz (1986) believe that "the use of personal journals, small study groups, and seminars facilitate the learning process by acknowledging and valuing" the individual's past and current thoughts and experiences (p. 94) whether student or client. In practice settings, nurses are and can be instrumental in helping women health care consumers identify their options and help them find physicians who will work "with" them rather than "on" them (Vachon, 1981). Nurses can be valuable sources of information and by moving away from the hierarchical relationship of nurse and patient to a collaborative relationship information can be freely shared so that women can make informed choices about their health (Fogel & Woods, 1981; Webster & Lipetz, 1986). Independent practice for

nurses will help to move nurses out of the hierarchy of the traditional health care system and facilitate the creation of alternative health care for women (Vance et al, 1985). This movement is already taking place as more nurses assume nurse practitioner roles in women's health clinics across Canada.

In applying the nurse's role more specifically to the care of climacteric women, the nurse must recognize the importance of treating each woman's experience of the menopause as unique. Nurses must also recognize that women's menopausal experiences will be influenced by other life events occurring within the context of their environment. Knowledge of menopause and need for information will vary from woman to woman and must be considered when planning care. How women learn about menopause and how women want information on menopause presented to them may be highly variable although movement away from a hierarchic teacher-student relationship would seem to be indicated. Of utmost importance for nurses is their attitude toward women experiencing menopause. Women need to feel that what they are experiencing is understood and its impact on their life valued.

In summary, nurses are becoming more involved in alternative health care for women (Dewar, 1982) and becoming concerned about the experiences of women, not just their diseases or childbearing functions. However, much work is still required by nursing in the areas of theory development, research, education and practice to meet the challenges of the women's health movement (Vachon, 1981; Vance et al, 1985; Webster and Lipetz, 1986; Woods, 1982).

Summary of the Literature Review

While the literature review is not an exhaustive one, it does serve to point out that research related to the informational needs of menopausal women is virtually non-existent. As well, the majority of research that has been conducted continues to be plagued by methodological problems (Bottiglioni and DeAloysio, 1982; Sarrel and Whitehead, 1985). The health care system has failed to value the experiences of women as evidenced by the research conducted "on" women and the negative view held of their experiences (Dunbar et al, 1981; Connors, 1985; Ford, 1986). Researchers have often neglected to address the meaning of the climacteric experience to women and continue to debate whether menopause is a biological or psychological phenomenon or a disease process (McPherson, 1985; Kaufert, 1985; Casper and Yen, 1985; Barbo, 1987). Debate also centres around the definitions of natural and artificial menopause and the climacteric and poses problems for researchers when comparing studies on the menopause. What symptomatology is characteristic of the menopause is unclear (Voda and George, 1986) although many physical and psychological problems have been attributed to this phase in a woman's life. The medical profession has tended to view menopause as a deficiency disease with HRT (Lufkin et al, 1988) as the mode of treatment. Much controversy surrounds the risks and benefits to women of HRT (Barrett-Connor, 1987; Gambrell, 1986; Jick et al, 1986; Kaufert

and McKinlay, 1985; Ladewig, 1985; Piziak and Shull, 1985) but to date no studies conclusively substantiate the safety or effectiveness of this therapy (Gleit and Graham, 1985; Guinan et al, 1987; Ross et al, 1988). In spite of this controversy, there is considerable pressure placed on physicians to prescribe HRT to women, particularly as a preventive measure against osteoporosis (Lufkin et al, 1988; Ross et al, 1988). Hysterectomy and oophorectomy are often performed in this stage of a woman's life for reasons that are not always clear (Anderson et al, 1987; Kasper, 1985). The impact of this type of surgery on a woman's experience of menopause may be of a negative nature (Anderson et al, 1987; Easterday et al, 1983; Menon et al, 1987). As physicians determine their role to be managers of women's health care, medicalization of the menopausal experience will likely increase (Notelovitz, 1987; Speroff, 1988). Women's perceptions of menopause are considerably different than those of the medical profession. They tend to view menopause as a normal, developmental transition in their lives (Frey, 1982; Griffith, 1983; Lennon, 1982). However, younger, pre-menopausal women seem to be more negative about menopause than peri- and post-menopausal women (Bowles, 1986; Muhlenkamp et al, 1983). Women with numerous roles tend to have better health than those with fewer roles (Uphold and Susman, 1985; Verbrugge, 1986). Employment outside the home impacts positively on the health of women (Hibbard and Pope, 1985; Jennings et al, 1984; Nathanson, 1980) while life events other than menopause produce

psychological distress in women (Cooke, 1985). Women are becoming more knowledgeable about menopause and mid-life health (LaRocca and Polit, 1980; Napholz, 1985) but tend to be obtaining information outside the health care system (Boston Women's Health Book Collective, 1985; Cobb, 1988) because of dissatisfaction with the system (Shapiro et al, 1983; Webb, 1986). Nurses are becoming more involved in alternative health care for women (Dewar, 1982) and are beginning to understand the complex phenomena that comprise women's health. Nurses, however, can play a greater role in the areas of theory development, research, education, and practice to meet the challenges of women's health and the women's health movement (Vachon, 1981; Vance et al, 1985; Webster and Lipetz, 1986; Woods, 1982). Nurses have a particularly important role to play in identifying those women who are seeking information about menopause and acting as a source of information to them. In meeting the informational needs of menopausal women, nurses must value the "lived" experiences of menopausal women and appreciate them as being distinct from men.

Chapter III

CONCEPTUAL FRAMEWORK

Few studies in the literature pertaining to the climacteric have examined what women actually know about this stage of life or want to know. Fewer still, if any, have studied the role of the woman as an active participant in searching for and acquiring information about the climacteric.

The conceptual framework for this study will focus on the information search model as described and studied by Lenz (1984). Lenz (1984) notes that information-seeking patterns of clients are important antecedents of health-related decisions and behaviors. She further contends that client information seeking is important to nursing for three reasons. First, active searching for health-related information is common among people. Secondly, clients often perceive that they are unsuccessful in getting the required information especially from health professionals. Thirdly, health and illness behavior is the outcome of a decision process and involves personal judgement (Lenz, 1984). Nurses need to be aware that individuals are searching for health information from health professionals such as themselves. Nurses also need to be cognizant of the fact that individuals make decisions about their health based on the information they already have or on newly acquired information.

Lenz, in developing her information search model, studied two bodies of literature: literature related to consumer

decisions and health care utilization. Consumer literature tends to emphasize overt information seeking but recognizes that information can also be passively acquired. The health care literature emphasizes the social dimensions of the search process. For example, "search" can be conceptualized as an interpersonal process since often another person is consulted. This body of literature has also helped to define the social context in which the search takes place e.g. socio-economic status, and the characteristics of individuals that influence the search process.

The information search process as conceptualized by Lenz (1984) is a subcomponent of the decision process and is comprised of six distinct steps:

1. a stimulus
2. goal setting
3. a decision whether to seek information actively
4. search behavior
5. information acquisition and codification
6. a decision regarding the adequacy of the information acquired.

Lenz (1984) conceptualizes the seventh component of the model as the outcome.

Lenz (1984) hypothesized that each step occurs sequentially and may vary along several dimensions, with the exception of steps three and six which are unidimensional. The search process

can be terminated at any point and can vary in duration and complexity.

The stimulus for the information search process may originate within the person e.g. disease process, or the external environment e.g. family discord (Lenz, 1984). Stimuli serve as a "call to action", signifying a discrepancy between information possessed and needed. Recognition of a problem to be solved or avoided, a choice to be made, a goal to be accomplished or actual or anticipated placement in an unfamiliar or threatening situation are common stimuli for the health-related information search. The degree of importance of the situation to the individual and the amount of uncertainty or risk associated with it will affect subsequent steps of the search process.

Information goal setting according to Lenz (1984) places parameters on the search and the information required. Individuals decide how soon information must be obtained, the information sources to be used, the kind of information desired and the alternatives to be explored. The search process can continue without goal setting but goal setting tends to focus the search to a greater extent. Lenz found, in a study of health care search, that individuals predefine time limits for receiving care and the kind of health care sources they would investigate. Immediacy of the required information was negatively related to the extent of the search.

Once a stimulus is present and recognized, with or without goal setting, a decision must be made whether to participate in

an active search for new information (Lenz, 1984). The prior information of the individual and the perceived cost-benefit both influence the decision. If individuals feel they have enough information they may decide not to search. Or if the costs e.g. frustration, time loss, outweigh the benefits, an active search is unlikely. Potential benefits not only include an increase in knowledge but also a reduction in anxiety and an increased sense of control. Many individuals do not participate in an active search if they can acquire information passively. For example, many clients do not ask questions because they believe health care professionals will tell them what they need to know.

Lenz (1984) identifies search behavior as encompassing two dimensions, the extent of the search and the method of search. The extent of the search is the total number of activities carried out and includes two components: scope (number of alternatives investigated) and depth (number of dimensions of an alternative investigated). The method of search looks at the information sources tapped. The method may be impersonal in which case information is sought from printed material or an unfamiliar person. On the other hand, the personal method involves obtaining information from a person known to the searcher (a consultant). Often a combination of these two methods is used. Direct observation is considered active search if undertaken in a purposeful manner. Studies show that personal methods are preferred to impersonal methods (Lenz, 1984). However, the value to clients of impersonal sources such as

written information should not be underestimated. The method of search used may influence the type and amount of information obtained. During an active information search, a client or individual may acquire very relevant information in a passive way because the individual is in a "high involvement" state i.e. keenly interested in the topic of the search.

Lenz (1984) notes that following the search activity, the information gained is evaluated in terms of prior information and a decision made as to whether it is relevant, irrelevant or redundant. Confounding variables in this step of the process include the ability to process and retain information, ex post facto measurement of information obtained, which measures information remembered versus information acquired, redundancy in information received, and a possible ceiling on information acquisition.

The sixth step of the process involves an evaluation of the adequacy of the information and a decision whether to continue or terminate the search (Lenz, 1984). Criteria for evaluation tend to be subjective and often include an examination of the information needed and obtained and/or a cost-benefit analysis. Often searchers err on the side of having minimal, incomplete information and discontinue the search because of that. Fatigue and frustration may also be contributing factors. Curiosity, interest, willing and competent consultants and adherence to previously set goals facilitate continuation of the search.

Lenz (1984) conceptualizes cognitive and behavioral outcomes as a seventh component of the information search process. The information acquired at the end of a search includes previously acquired information, information acquired actively as part of the search and information passively acquired during the search. Other cognitive outcomes include changes in opinions, beliefs, or attitudes as well as in perceptions of self, others or the environment. Behavioral outcomes tend to follow cognitive processes and often reflect a conscious choice of some type e.g. type of health service used. Information, however, may be only one of several variables that affect discretionary health behavior.

Lenz (1984) outlines three types of variables that are "potential predictors of variation in search behavior" (p. 66). The first variable is the background of the searcher which includes socio-demographic characteristics and previous health experiences. For example, older adults and adults from a lower socio-economic status are least likely to engage in search behavior; women are more likely to engage in more extensive health searches than men. Other socio-demographic variables that influence search behaviors are marital status, employment status, and ethnicity. Previous experiences interact with socio-demographic variables to influence the information search e.g. individuals previously hospitalized are less likely to seek information about hospitalization than those experiencing initial hospitalization. A second important variable is the personality

of the searcher. Six inter-related personality characteristics have been identified as influencing the extent of search behavior. They are: "tolerance for ambiguity, self-esteem, need for cognitive clarity, rigidity, trait anxiety, and cognitive style" (Lenz, 1984, p. 67). The first three characteristics relate positively to the search process while rigidity and anxiety tend to interfere with the process. Cognitive style can have either a positive or negative effect. Individuals who have an internal locus of control are more likely to engage in information seeking than those with an external locus of control. The third group of variables relate to the conditions under which the search behavior is performed. Contextual variables such as time constraints and the physical and interpersonal environment play an important role in search behavior.

In summary, the information search process as described by Lenz (1984) consists of six distinct steps: a stimulus, goal setting, a decision whether to seek information actively, search behavior, information acquisition and codification, and a decision regarding the adequacy of the information acquired. A further component of the information search process is the cognitive and behavioral outcomes. Lenz (1984) identifies three types of variables that influence search behavior. These variables are the background of the searcher, the personality of the searcher, and the conditions under which search behavior is performed.

Chapter IV

METHODOLOGY

In reviewing the literature, little information regarding the information search process in climacteric women was found. For this reason, a qualitative approach was undertaken in this study to describe more readily the variables that pertain to the information search process in climacteric women. As Knafl and Howard (1984) note, qualitative research is important in that it provides a richness and detail of data that helps the reader to understand the subject's social world. By using a qualitative approach the "inner experience and outer behavior of a subject as viewed by both the researcher and the participants" is valued (Rist, 1979, p. 19). Swanson and Chenitz (1982) point out that qualitative research facilitates the study of the "world of everyday experience" (p. 242) as it describes or explores the events or culture under study. Qualitative research is useful to nurse researchers in practice settings as it may help to explain a host of variables interacting at the same time at different levels of abstraction (Swanson and Chenitz, 1982). McBride and McBride (1981) emphasize the importance of examining the "lived experiences" of women in general and as they relate to health in particular. A methodological consequence of this philosophy is to utilize a qualitative approach in studying women's health. In this study, a qualitative approach provided the researcher with an opportunity to describe the menopausal experiences of women,

the information search process as it relates to menopause, and the contextual variables that may impact on both menopause and the information search process.

Purpose of the Study

The purpose of this study was to describe the information search process in climacteric women. In addition to the information search process, the socio-demographic characteristics and the attitude toward menopause of women who were searching for information were described.

Design

A comparative, descriptive design was utilized in this study to examine and describe the information search process variables in two groups of climacteric women. Both groups were from natural settings, namely the Menopause Information Workshop (MIW) sponsored by the Women's Health Clinic (WHC) and a Winnipeg Hospital Nurses' Alumnae (Alumnae). A survey of these two groups of climacteric women was conducted using an interview and a short questionnaire.

In describing the information search process in climacteric women, an attempt was made to answer the following research questions:

1. What variables in the climacteric serve as a stimulus for a woman to engage in the information search process?

2. What kinds of information do women want about the menopause/climacteric?

3. What is the method and extent of the search for information by the climacteric woman?

4. What positive experiences and problems were encountered in searching for information?

5. What factors influence a woman's evaluation of the acquired information?

6. What factors serve as a cue to further search behaviors? What factors serve as a cue to terminate the search?

7. What are the cognitive and behavioral outcomes of an active information search by climacteric women?

8. What is the attitude toward menopause of climacteric women who are seeking information? What is the attitude of those who are not?

9. What are the socio-demographic characteristics of climacteric women who are searching for information?

Assumptions

1. Some climacteric women require information about the menopause.

2. Some climacteric women are seeking information about the menopause.

3. Some climacteric women will be willing to share their behaviors regarding the information search process.

4. Women registered for the Menopause Information Workshop (MIW) are assumed to be in the active phase of the information search process.

5. Attitude toward menopause will have some effect on the information search process.

Definition of Terms

1. Menopause: the last menses (Kaufert, 1980; Voda & George, 1986).

a) Natural Menopause: --"at least 12 months of amenorrhea, not obviously attributable to other causes" (Kaufert et al, 1986, p. 1286).

b) Artificial Menopause: cessation of menstruation by reason of surgery, chemotherapy or radiotherapy.

2. Climacteric: a gradual process of ovarian failure which precedes and extends beyond the last menses. It includes a series of stages known as the pre-menopausal, peri-menopausal and post-menopausal stages (Kaufert, 1980).

a) Pre-menopausal: that stage during which a woman 40 years of age or older is still menstruating regularly.

b) Peri-menopausal: that stage during which a woman's menstruation has become irregular or has taken place in the last 12 months but not in the past 3 months.

c) Post-menopausal: that stage in which a woman has not menstruated in the last 12 months.

Population and Sample

Two populations were identified for the study. The first population was women ages 40-60 years of age who resided in Winnipeg and who had attended a MIW session sponsored by the WHC. Volunteer subjects were obtained from two separate sessions of the MIW. Enrollment in the first session was 26; the second session was 24 women. A convenience sample of 14 women volunteered from the two sessions of the MIW, approximately one-quarter of the total population. Only one of the 14 women from the MIW who volunteered did not participate in the study. The second population was women ages 48-52 years who belonged to the Alumnae of a Winnipeg hospital, were graduates of the classes 1956 through 1960, and resided in Winnipeg. The size of population eligible to participate was 29. Nine (9) women volunteered from the Alumnae, slightly less than one-third of the total population. All nine volunteers from the Alumnae participated in the study. Two (2) women from each group were selected for pilot testing of the tools, leaving a sample size of 11 in the MIW group and 7 in the Alumnae group.

An effort was made to draw subjects from populations that were non-clinical in nature although subjects may have been under a physician's care at the time. Criticism has been levelled at many research projects in that their samples were drawn from groups of women seeking medical attention for their menopausal symptoms (Sarrel & Whitehead, 1985).

Women who had had hysterectomies, partial or total oophorectomies and/or were on hormone replacement therapy were included in the study as these variables were thought to have a significant impact on the information search process.

Subjects were required to read and speak English in order to respond to the interview and short questionnaire. No woman was excluded from the study on the basis of her religion, culture, socio-economic or marital status.

The two groups of subjects were different in several respects. First, the age ranges were dissimilar in that those women who registered for the MIW could fall into a broad age band e.g. 40-60 years. Since it was assumed these women were in an active phase of the information search process, it was important to obtain data from all ages. On the other hand, the age range of 48-52 years was selected to increase the probability that the Alumnae group would be peri-menopausal and that the topic of menopause would be pertinent.

The second difference between the groups was their occupational status. The Alumnae group was comprised entirely of nurses while the MIW group was a mixture of occupations.

There were sampling biases inherent in the study. For example, it could be said that the MIW, because of its association with the WHC, attracts only those women with menopausal problems who are already under a physician's care. A second source of sampling bias is the nature of the Alumnae group. Because they are nurses and already possess a certain

knowledge base, their information search behaviors could be markedly different. The samples are also not representative of the general population.

Setting

The MIW is a day long symposium of related topics (see Appendix A). The topics include female anatomy and physiology, menopausal changes and how to deal effectively with them, nutrition in menopause, osteoporosis, hormone replacement therapy, social and interpersonal issues of aging and menopause as well as information on resource materials. The Workshop leader is a nurse. The nurse presents the material informally with opportunity for women to question or make comments during the session. Some topics are dealt with in small discussion groups; a film is also used followed by discussion. A nutritionist presents the content related to nutrition in the menopause and prevention of osteoporosis. The MIW approaches menopause from a feminist perspective, thereby encouraging women to utilize natural rather than medical approaches to menopausal problems they have or might encounter. The workshop leader, however, is careful to present both the benefits and risks of particular therapies e.g. HRT.

The MIW is sponsored by the WHC. The workshop is advertised through the media thereby attracting women who are not necessarily clients of the WHC. WHC is a primary health care centre that seeks to provide alternative health care to women

within a feminist context. A large proportion of clients come to the clinic for reproductive counselling as well as for other programs e.g. pre-menstrual syndrome support group, MIW, perceived overweight support group and teen drop-in.

The Nurses' Alumnae (Alumnae) is a voluntary organization whose main purpose is to further the practice of nursing through support of their School of Nursing. There are approximately 100 active members as well as an Executive Committee. The Executive and the general membership meet on a regular basis throughout the year.

The actual setting where data collection took place was mutually agreed upon by the respondent and the researcher. Areas considered to be the researcher's "territory" were avoided e.g. her home or office, in order to minimize environmental influences.

Data Collection

Instruments

The research questions were operationalized through the use of Bowles (1986) Menopause Attitude Scale (MAS) (see Appendix B), a short self-administered questionnaire developed by the researcher eliciting socio-demographic data, and a semi-structured interview developed and conducted by the researcher (see Appendix C).

The MAS is a semantic differential instrument measuring adult women's attitudes toward menopause. The MAS was chosen for

use because of the assumption that attitude toward menopause might have some effect on the information search process. For example, women with a more negative attitude toward menopause may be searching for information because they are having difficulty with the menopausal experience. It was also chosen to determine if there was congruence between attitude toward menopause and the verbal expression of feelings toward the menopausal experience. The MAS is a seven point scale with the positive adjective at the seven point end. The higher the MAS score, the more positive the attitude toward menopause. It has a test-retest reliability of r= .87. Convergent validity has been demonstrated with a correlation of r= .63 and discriminant validity with a correlation of r= .42. Multiple regression analysis identified age and menopausal status as providing significant explanation for MAS scores. The Cronbach alpha reliability coefficient was .96. Permission to use the MAS was granted by Bowles with the understanding that a copy of the results would be forwarded to her.

Tools developed by the researcher, namely the short questionnaire and the semi-structured interview, were pre-tested using a cohort of four women, two being selected from each group.

The semi-structured interview was conducted first. Two interview formats were used e.g. one for the MIW group and one for the Alumnae group, as the assumption was made that women attending the MIW were in the active phase of the information search process while the stage of the Alumnae members was yet to

be determined. The researcher made notations throughout the interview as well as tape recorded it. The interview took approximately one hour.

The self-administered questionnaire including the MAS was completed at the end of the interview and took approximately 15 minutes. The reason for doing this at the end was so the feelings the scale might elicit would not affect the course of the interview. The researcher recognizes, however, that the interview may have affected the responses to the MAS.

Reliability of the data collection tools were promoted through the researcher conducting all the interviews and through consistency in regard to explanation of the study.

Content validity was established by experts in the area examining the questionnaire and semi-structured interview for inclusion of all important items/concepts that comprised the domain of study e.g. menopause, women's health, nursing.

Entry into the Setting

Permission to invite women who attended the MIW to participate in the study was sought from the Board of Directors of the WHC. A letter was sent to the Chairperson of the Board requesting this permission and it was subsequently granted. Once permission was granted, women attending the MIW were approached regarding the study.

Permission to contact female nurses ages 48-52 years who were residing in Winnipeg was requested from the Executive Committee of the Alumnae. A letter was sent to the President of

the Alumnae requesting this permission and it was subsequently granted. In contrast to the women attending the MIW, alumnae members from classes 1956 through 1960 were contacted initially by a letter from the Executive Committee inviting them to participate. The reason for initial contact by letter rather than in person was that membership attendance at general meetings is varied e.g. there is often a preponderance of elderly, retired nurses and new graduates with considerably less representation from the 48-52 age group. It was anticipated that only the alumnae members of the graduating classes of 1956 through 1960 would need to be considered as most nurses graduating in that era were approximately 21 years of age.

Protection of Human Subjects

Approval from the Ethical Review Committee of the School of Nursing, University of Manitoba was received before any contact was made with the Board of the WHC and the Executive of the Alumnae. As well, approval from the Board of the WHC and the Alumnae Executive was received before respondents were contacted in any way.

As indicated earlier, women attending the MIW were approached during the session. A sheet explaining the study and inviting them to participate was distributed to them (see Appendix D). The researcher explained the study and answered any questions they had. Willingness to participate in the study was confirmed by having those who were interested sign a consent form (see Appendix E). Mutually convenient dates, times and places

for the interview and questionnaire were arranged between the respondents and the researcher by telephone.

Initial contact with female nurse alumnae members was by letter from the Executive Committee (see Appendix F). An invitation to participate in the study was enclosed with the letter (see Appendix D) as well as a means of indicating their interest in doing so. A stamped envelope addressed to the Alumnae Executive was also enclosed. Once the Executive had received the affirmative responses from alumnae members, their names and addresses were then given to the researcher. Subsequent to this a telephone call was made to the alumnae member to plan a mutually convenient time to meet for the interview and questionnaire (see Appendix G). Confirmation of informed consent was obtained in writing at the time of the interview (see Appendix E).

Participation in the study was voluntary and respondents could withdraw from the study at any time or refuse to answer any of the questions. Respondents' names were not used on the questionnaire or interview data but rather were identified by number. Only the researcher and her advisory committee had access to the raw data. The raw data was kept in a locked box and will be destroyed one year after the study is completed. Data from the study were presented in such a way that individual respondents could not be recognized in the report or in any future publications. Respondents desiring a copy of the study results were provided with one.

During the interviews with respondents, it was anticipated that a number of women would have questions pertaining to themselves and their menopausal experience to which the researcher could provide answers. Provision was made at the end of the data collection period to answer these questions. If the researcher was unable to answer the questions, alternative arrangements were made for the respondent to obtain the necessary information.

Data Analysis

Notes were taken by the researcher during the course of the interview. A tape recording of the interview was made with the respondent's consent. Following the interview, the researcher listened to the recording and added to the written notes as required. Content analysis was used to give meaning and structure to the collected data. In performing the analysis, Lenz's (1984) model of the information search process was instrumental in developing the categories and answering the research questions.

The MAS was used to measure attitude toward menopause. The respondents' scores from the semantic differential scale were tabulated to provide a total score for each individual woman. The total score was a reflection of the woman's attitude toward menopause. The higher the MAS score, the more positive the attitude.

Descriptive statistics, e.g. frequency distributions, were used to summarize the socio-demographic characteristics of the sample.

In summary, a comparative, descriptive design was utilized to describe the information search process in two groups of climacteric women. In addition, data regarding socio-demographic characteristics and attitude toward menopause were collected. The findings from the study will subsequently be presented.

Chapter V

FINDINGS

The purpose of this study was to describe the information search process in climacteric women. In addition, the socio-demographic characteristics and the attitude toward menopause of women who were searching for information were described. Two groups of women from natural settings were utilized: those women who had attended the MIW sponsored by the WHC and members of a Winnipeg Nurses' Alumnae Association. Eleven (11) women from the MIW and seven (7) from the Alumnae participated in the study which consisted of a semi-structured interview and a short questionnaire. Content analysis was utilized to analyze the data.

The data from the semi-structured interviews and self-administered questionnaires are presented according to the following format:

1. Sample characteristics
    1) Socio-demographic description.
    2) Community activities.
    3) Recent stressful life events.
    4) Menopausal status.
    5) Physician care, medications taken, and surgery.
    6) Attitude toward menopause.
2. Description of menopausal experience.
3. Feelings toward the menopausal experience.

4. Kinds of information useful to climacteric women.
5. Stimuli for seeking information/not seeking information.
6. Extent and method of search.
7. Problems encountered during the search.
8. Positive experiences during the search.
9. Factors pertaining to evaluation of information.
10. Factors involved in continuing or stopping the search for information.
11. Changes made in life/lifestyle.
12. Description of greatest problem/concern/worry.
13. Other comments.

As data are presented, whether the data are from the women attending the MIW or from the Alumnae will be indicated.

Sample Characteristics

1) Socio-demographic Description

The mean age of the women from the MIW was 47; the mean age for the Alumnae group was 51 years. The majority of the MIW group were married while all women from the Alumnae group were married. The majority of women from the MIW had children with one or more children living at home; all women from the Alumnae had children with one or more living at home. The majority of women from both groups were employed. All women from the MIW group except one had a high school education or beyond; all Alumnae members had a post-secondary diploma or beyond.

Table 1 describes the socio-demographic characteristics of both groups of women in more detail.

TABLE 1

Socio-demographic Characteristics
of the MIW and Alumnae Groups

CHARACTERISTIC	MIW GROUP (n=11)	ALUMNAE GROUP (n=7)
AGE		
Range	41-57 years	49-53 years
Mean	47 years	51 years
MARITAL STATUS		
Married/Common-law	8	7
Separated	1	0
Divorced	1	0
Single (Never Married)	1	0
CHILDREN		
Yes	9	7
No	2	0
Number (Range)	1-4	1-4
At Home		
- none	1	0
- one	5	4
- two	3	3
- range in age	15-26 years	19-34 years
EMPLOYMENT		
Yes	9	5
No	2	2
Full-time	8	2
Part-time	1	3
Professional Position	4	5
Non-professional Position	5	0
EDUCATION		
Partial Completion - Grades 10, 11 or 12	1	0
High School Certificate	3	0
Diploma/Certificate - Post-secondary Institution	3	4
University Bachelors Degree	2	1
Advanced University Degree	2	2

2). Community Activities

More than half of the women from the MIW were involved in community activities. All but one of the Alumnae women were involved in community activities. The Alumnae members' activities tended to be more church-related while those of the MIW were more general.

3). Recent Stressful Life Events

When asked if they had experienced any recent events in their lives that had been upsetting or stressful to them, all but two of the women from the MIW said "yes". Four of the Alumnae women said "yes" and three said "no" to this same question. One woman from the MIW cited her hysterectomy as being stressful; none of the other women in either group mentioned menopause or factors related to menopause as being stressful.

4). Menopausal Status

Women from both groups were asked when they had had their last menstrual period. According to their responses, the majority of women from the MIW had menstruated in the last three months while the majority of the Alumnae women had not menstruated in the last two or more years. When women from both the MIW and Alumnae were asked where they thought they were in terms of beginning or completing the menopause, the MIW group said they were beginning menopause or in the middle. The Alumnae group said they were in the middle of menopause or all through with it.

Tables 2, 3 and 4 illustrate in greater detail the menopausal status of both groups of women and their perceptions of their menopausal status.

TABLE 2

Menstrual Status - MIW and Alumnae Groups

MENSTRUAL STATUS	MIW GROUP (n=11)	ALUMNAE GROUP (n=7)
Menstruated in Last 3 Months	7	1
Menstruation Ceased		
- Naturally	2	3
- Surgically	2	3

TABLE 3

Perception of Menopausal Status - MIW and Alumnae Groups

PERCEPTION OF MENOPAUSAL STATUS	MIW GROUP (n=11)	ALUMNAE GROUP (n=7)
Without any Sign of the Menopause	0	0
Just Beginning the Menopause	5	1
In the Middle of the Menopause	6	3
All Through with the Menopause	0	3

TABLE 4

Menstrual Status and Perception of Menopausal Status - MIW and Alumnae (A) Groups

	BEGINNING-MENOPAUSE	MIDDLE-MENOPAUSE	THROUGH-MENOPAUSE
MENSTRUAL STATUS			
Menstruated in Last 3 Mos.	MIW-4 A-1	MIW-3 A-0	MIW-0 A-0
Menstruation Ceased -			
- naturally	MIW-0 A-0	MIW-2 A-1	MIW-0 A-2
- surgically	MIW-1 A-0	MIW-1 A-2	MIW-0 A-1

Table 4 illustrates some consistency between the last menstrual flow and perception of menopausal status although it does not take menstrual pattern into account.

5). Physician's Care, Medications Taken, and Surgery on Uterus and/or Ovaries

When women from the MIW were asked if they were under a physician's care, the majority said "yes". Two of the women were seeing a doctor because they were presently on HRT; both women had intact ovaries. The other women were seeing their doctors because of endometriosis, fibrocystic breast disease, aching feet and legs, and because of proposed ankle surgery. One woman was getting a second opinion as hysterectomy and oophorectomy had been recommended to her because of an enlarged uterus. Only two women from the Alumnae group said they were under a physician's care. One of the two women was seeing a doctor for monitoring of

sarcoidosis which has since disappeared; the other for monitoring of slightly elevated blood pressure.

When women from the MIW were asked what medications they were taking and why, the majority were taking medications although only two were taking HRT because of menopause. Neither of the women who were taking HRT were artificially menopausal. The most frequently taken medications were Calcium supplements and vitamins. The majority of women from the Alumnae were taking medications regularly with only one woman taking ERT for prevention of osteoporosis; another woman took Dixarit (Clonidine) occasionally for hot flashes.

The majority of women from both the MIW and Alumnae groups had had surgery on their uterus and/or ovaries. Cancer, endometriosis, ovarian cyst, cystic hyperplasia, and fibroids were the major reasons why hysterectomies and/or oophorectomies were performed.

Table 5 describes the utilization of physician's services by the women from the MIW and Alumnae groups, the medications being taken by both groups and the amount and type of surgery they had experienced.

6). Attitude toward Menopause

Women from both groups completed the MAS, a semantic differential instrument that measures adult women's attitudes toward menopause. The scores for the group from the MIW ranged from 59 to 113 with a mean of 86.8. The scores of all the women from the Alumnae group ranged from 72 to 138 with a mean of

102.57. The mean for the women from the Alumnae who had looked for information was 105; the mean for those not seeking information was 101.6. Bowles (1983), in validating the MAS, tabulated a mean of 82.31 with a sample of 419 adult females. Scores for the MAS can range from 20 to 140 with the higher score reflecting a more positive attitude toward menopause than the lower score.

TABLE 5

Physician's Care, Medications Taken, and Previous Surgery (Uterus and Ovaries) - MIW and Alumnae Groups

	MIW GROUP (n=11)	ALUMNAE GROUP (n=7)	TOTAL GROUP (n=18)
PHYSICIAN'S CARE			
No	4	5	9
Yes	7	2	9
Reason			
-Menopause	4	0	4
-Other	3	2	5
MEDICATIONS			
Not Taking	3	1	4
Taking	8	6	14
Type			
-ERT or HRT	2	1	3
-Calcium	4	0	4
-Other	13	5	18
SURGERY ON UTERUS AND/OR OVARIES			
No	4	1	5
Yes	7	6	13
Type			
-Tubal Ligation	3	4	7
-Hysterectomy / Oophorectomy	3	3	6
-D & C	1	2	3
-Other	1	1	2

Description of Menopausal Experience

Both groups of women described the menopausal changes that they were presently experiencing or had experienced in the past. Of the women interviewed who had attended the MIW, the majority had experienced hot flashes and/or flushes. Some of the women experienced their first hot flash/flush at a relatively young age. For example, one woman started with flushes at age 40. She thought she was getting a flu and that menopause was "far away". Another woman felt that her menopausal changes had started when she was 30 as she began having hot flashes then.

Women from the MIW commonly found that certain factors would trigger a flash or flush. Hot liquids, such as coffee and tea, sugar, caffeine and hot, spicy foods were often implicated. A hot room, being startled, stress and worry also triggered them.

The nature of the flash/flush varied. On the third day following her hysterectomy and oophorectomy, one 43 year old woman experienced flashes that lasted for approximately 30 to 60 minutes with an after-chill that made her feel "cold to my core". Another woman described her flashes as a "very uncomfortable feeling" that was sudden in onset. The flashes made her very "sweaty" but lasted for only a few minutes. Areas of the body affected by flashes were the face, ear lobes, hands and feet. One woman described the flash as being "around her head".

The occurrence of the hot flashes and flushes varied. For example, one woman felt there was "no rhyme or reason" to them in that they were "sometimes really bad then tapering off". Another

women said her flashes occurred in "cycles" e.g. will have flashes for a week to a week and a half and then none for a month. One woman did not experience any hot flashes until two years following her last period. Another woman who missed her period for two and a half months experienced severe flashes during that time. Once her period returned, the flashes disappeared.

The women from the Alumnae group, when describing their menopausal changes, had also experienced hot flashes or flushes. All but one of the seven women had had this experience. As with the MIW group, the occurrence of the hot flashes/flushes varied. For example, one woman who had had a complete hysterectomy and oophorectomy for an ovarian cyst started experiencing hot flashes regularly two days following her surgery. Another woman said her hot flashes began two years before she stopped menstruating.

The frequency of the flashes for the Alumnae group varied. One woman said she sometimes had as many as 50 a day or none at all. She was on Dixarit for a time but did not continue as she is a "poor pill-taker". Her mother had cancer so she did not want to take hormones because of the risk. Another woman said her hot flushes would last for several weeks and then go away for several months and then come back again. When she experienced flashes she might have four flashes in an hour or every two hours and they would last approximately 3-4 minutes.

Some of the women from the Alumnae said their flashes were becoming less intense. For example, one woman was still

experiencing approximately six flashes per day but found that they were short and "quite easy now compared to after surgery" (hysterectomy and bilateral oophorectomy). Another woman said she used to have flashes 4-7 times in one day and found them to be quite intense. Now the flushes are just a feeling of warmth and occur about once a day.

The majority of the women from the MIW had experienced changes in their menstrual cycles. Two of the women from the MIW had had hysterectomies, with one of the two also having a bilateral oophorectomy. The menstrual cycle changes experienced by the women were increased cramping during menstruation, flooding, shortening of the cycle, increased regularity, missed periods, heavier periods, lighter periods, slower starting periods and late periods. Some of the women from the Alumnae group had also experienced changes in their menstrual cycles as part of their past and present menopausal changes e.g. irregular periods, abnormal flow.

Night sweats were another characteristic of the menopausal experience for more than half of the MIW group. Some women had both night sweats and hot flashes; others had only night sweats. The women who experienced the night sweats found that they became very hot and would throw off their bedclothes. Only two of the women from the Alumnae group presently had night sweats with one of the two women experiencing both hot flushes and night sweats.

The majority of women from the MIW said they had experienced "mood swings" or some change from their usual emotional state. For example, some would "cry easily", feel some self-pity, feel depressed or anxious, worry, become impatient, anger more quickly or have difficulty coping with crises. In contrast to this, only one woman from the Alumnae group mentioned any change in her emotional status, the change being an improvement in her mood.

Less than half of the women from the MIW and the Alumnae groups experienced sleep pattern disturbances. These disturbances were related mainly to night sweats.

Some of the women from the MIW group said they had bodily aches and pains and/or "sore" bones. For example, one woman said her spine hurt and that her head would not hold up. She summed it up by saying "My bones won't hold up my body". She also said that she felt so much more frail than before. Only one woman from the Alumnae had noted joint, hip and back pain.

A small number of women from the MIW group experienced numbness and tingling in their heads. These women had had brain scans done to determine if these behaviors were indicative of some pathology. Results were negative. These women were relieved to hear from the MIW that other women had also experienced similar changes. A few women from the MIW commented that they had experienced headaches but had not found them to be "overwhelming". One woman from the Alumnae group mentioned that her migraine headaches had ceased after her menopause. These

headaches had begun when she started taking the birth control pill at age 30.

A small number of women from the MIW mentioned breast changes as part of their menopausal experience. These changes were fibrocystic in nature. One of the women said that her breasts were so sore sometimes it was difficult for her to walk. The soreness was aggravated by "using her arms a lot". At one time it was related to her period but this is no longer so.

A few women from the MIW mentioned they had experienced changes in their sex drive. The main change in sex drive was related to loss of interest in sex as opposed to a previous interest. For example, one woman indicated that it bothered her because she was not as interested in sex as before. She used to enjoy sex but now feels like a failure because of her lack of interest. One woman from the Alumnae group also mentioned a decreased interest in sex.

A small number of women from both the MIW and Alumnae groups indicated that fatigue was a change for them. They tended to tire more quickly, require more sleep and be unable to do all of the things they had done previously. One woman who began "spotting" in her late thirties mentioned that this made her very tired. Another woman whose menopausal changes began at age 45 said that she was "extremely tired for the first six months".

Two women from the Alumnae and one from the MIW mentioned that they had experienced changes in weight and fat distribution e.g. weight gain, greater fat distribution around the waist.

Other individual menopausal changes that women from the MIW noted were nausea, inability to think or speak as well or clearly as before, vaginal dryness and urinary frequency because of an enlarged uterus. Individual changes that the Alumnae group mentioned were memory lapses, bloating and vaginal dryness.

Two women from the MIW were taking HRT. One of the women who was 48 years of age had just started taking HRT the month she was interviewed. To date, she felt that the uterine "cramping" which she had been experiencing had been alleviated by the HRT. Other menopausal changes that she was presently experiencing were fatigue, irritability, disturbed sleep patterns because of nightmares and sweats, irregular periods, nausea, hot flushes, a spine that hurt, and some depression and anxiety. The second woman who was taking HRT was 47 years of age. Her first menopausal changes began at age 46 when she experienced a night sweat and "some changes in periods". This prompted her to go to her gynecologist who encouraged her to take HRT "before encountering any symptoms". Because of this it was hard for her to tell "what her normal body functions would be".

Only one woman from the Alumnae was presently taking ERT. She had taken Premarin for four months at the time of the interview because of a family history of osteoporosis e.g. her mother has severe osteoporosis.

Table 6 presents an overview of the menopausal changes experienced by the MIW and Alumnae groups.

TABLE 6

Menopausal Changes Experienced by MIW and Alumnae Groups

MENOPAUSAL CHANGES	MIW GROUP (n=11)	ALUMNAE GROUP (n=7)	TOTAL GROUP (n=18)
Hot Flash/Flush	7	6	13
Changes in Menstrual Cycle	9	3	12
Night Sweats	6	2	8
Changes in Emotional Status	6	1	7
Sleep Pattern Disturbances	4	2	6
Bodily Aches/Pains	4	1	5
Numbness and Tingling in Head	2	0	2
Headaches	2	0	2
Breast Changes	2	0	2
Change in Sex Drive	2	1	3
Fatigue	2	2	4
Changes in Weight and Fat Distribution	1	2	3
Vaginal Dryness	1	1	2
Changes in Thought and Speech Processes	1	1	2
Other e.g. nausea, bloating	2	2	4

In summary, the most common menopausal changes experienced by both the MIW and Alumnae groups were hot flashes/flushes and menstrual cycle changes. The nature and occurrence of the hot flashes/flushes varied for both groups. Some of the women from the Alumnae group, however, noted that their flashes were becoming less intense. The MIW group commented more frequently on changes in emotional status than the Alumnae group. In addition, they had experienced several changes that the Alumnae group had not e.g. numbness and tingling in head, breast changes, and headaches.

Feelings toward the Menopausal Experience

How women from the MIW felt about their menopausal changes varied. Approximately half of the women expressed "negative " feelings about their particular situation; fewer than half were "positive " about the changes and a very few had "mixed" feelings. Women from the Alumnae group tended to feel "positive" about their menopausal changes and experiences. All but two of the women responded with positive comments.

Those women from the MIW whose feelings were categorized as "negative" expressed fears related to aging and the unknown, anger at themselves, families and physicians, and concern regarding physicians' attitudes toward their bodies. Negative feelings were also expressed in relation to actual physical pain endured for a number of years. One 47 year old woman who was still menstruating said "I'll fall apart when I hit menopause".

She identified that she was very conscious of age as she works with young people on a regular basis. At the time of the interview, she had been told by her physician that she needed a hysterectomy and oophorectomy because of an enlarged uterus. The message she got from her physician was that she did not need her ovaries anymore because she was over 45. This message made "my hair stand on end". She also felt that this particular physician did not like women. She was concerned about the surgery because when she had a tubal ligation at age 40 she experienced a great sense of loss and did a lot of crying. She was afraid that a similar situation would occur with the hysterectomy and oophorectomy.

Another woman of 44 years who had had a hysterectomy and oophorectomy for endometriosis expressed concerns related to the "nonchalance" of physicians toward hysterectomy. They (the doctors) think it's "so easy"; they treat it "like a tonsillectomy". She identified that she needed to work through feelings related to hysterectomy as well as to menopause. In addition this woman had suffered for years with dysmenorrhea and was not diagnosed as having endometriosis until she was 39. She shared some strong feelings in relation to this. She felt that women were not understanding unless they themselves had endometriosis. She also felt that if men had dysmenorrhea they would not tell her it was "in your head". This particular woman had planned her whole life around her menstrual cycle as the pain was so severe on the first day of her period that she was unable

to work. This caused her to be very "uptight" as her periods were irregular and she could not always reschedule activities as necessary. Since turning 40 she feels that her body is "falling apart". She has developed a hearing loss, has polycystic breast disease and her hair is greying.

Another woman of 50 who had stopped menstruating at 45, said "It (menopause) will pass". Somedays she gets "fed-up" but knows that she can get through menopause as she got through raising three sons on her own. She mentioned that her family does not always understand her mood changes.

One woman of 48 who was still menstruating was angry at her family for not recognizing how she felt. She felt her husband was reluctant to understand her changes. He had had a heart attack and she had to learn about his problems but he did not want to reciprocate. She was also angry because she could not do the things that she normally does because of her fatigue. She indicated that she was the "leader" in the house and "When mother lies down, the whole house lies down". She expressed the thought that it is "a man's world" and if we had more women doctors, we would know more about menopause. This particular woman had just started taking HRT for her menopausal changes.

Another woman of 47 who was still menstruating identified that she was angry with herself because her gynecologist encouraged her to go on HRT before encountering any real symptoms. She said she got a lot of pressure from the gynecologist to take HRT. In fact, he had compared not taking

HRT to not planning for her financial future. She was frustrated with the situation because she was not involved in the decision-making and angry with herself because she had gone along with it. She has now decided to stop the HRT because of a strong history of cancer in her family. Her family doctor is supportive of this decision and she is relieved that she has decided to stop the HRT. She said that she has struggled with breaking the relationship with her gynecologist as he has been a "good" source of information over the years.

One of the women from the Alumnae who expressed some "negative" feelings about her menopausal changes said she wished "it was over with". She said it was annoying to be wearing heavy clothes and then wanting to take them off. Her sleep is disrupted and she is looking forward to "sleeping through the night". She also expressed feelings of embarrassment because of the flushing and redness in her face even though others say they don't notice it.

The MIW women who expressed "positive" thoughts about menopause seemed to feel that it was a normal phase of life. One 42 year old woman said "it (menopause) is normal" and that she did not mind growing older. Another woman said menopause was a natural process and that "you need to put up with some things the same way you do when you are pregnant". She said she was not depressed by menopause but was taking it "in her stride" as that is the nature of her character. She saw menopause as another "phase in life". A 57 year old woman said she was ready for

menopause and that it was a part of life. A 48 year old woman who had stopped menstruating said she felt positive about menopause because she did not need to worry about birth control any longer. She said she was also glad that her period had just stopped and that there had been no tapering off process.

The majority of women from the Alumnae were positive about their menopausal changes because they felt better now than they had previously, were relieved because they could no longer become pregnant, and they felt it was a normal process. For example, one woman said that she "feels better now than she has in 20 years". She had had an ovarian cyst the size of an orange removed along with both ovaries and her uterus. She thinks the cyst had been there for a good many years and that it had bothered her for a long time. Eight months after this surgery she had her gall bladder removed as she had had chronic gall bladder problems for about 10 years. She also added that her mood was fine, in fact, better because she no longer had the "menstrual ups and downs". She said she was never depressed throughout any of her experiences. Because she feels so much better, this has given her the impetus to make some lifestyle changes e.g. quit smoking, start exercising. She said she "doesn't just feel better but looks better too".

Another woman from the Alumnae commented that she felt "tremendous" after her hysterectomy which was done for cystic hyperplasia. As for her menopausal changes, she said "you expect them, you know it's going to happen but you can't predict how it

will be for you". She said it was not a negative experience; "your friends are in the same category and you can discuss with them". Friends often ask her questions since she is a nurse. This particular woman had started ERT four months ago for prevention of osteoporosis as her mother has severe osteoporosis.

Another woman from the Alumnae group who had stopped menstruating five or six years earlier felt menopause was "a bit of a relief". She had been influenced by an aunt who had 10 children and who had said "thank goodness" when she stopped menstruating. This particular woman felt quite happy about it as she had never "dreaded" menopause and did not feel her life was over as some women do.

Another Alumnae member of 49 years of age who was still menstruating commented that she was not "frightened" of the menopause. She didn't like the perspiration but the extra weight didn't concern her as she was very skinny. Another woman said that the menopause was "natural - a part of life and that's it".

Two women in the MIW group said they had "mixed" feelings about the changes they were experiencing; none of the Alumnae women expressed "mixed" feelings. The mixed feelings centred mainly on growing older and changes in emotional status. One 41 year old woman from the MIW who expressed mixed feelings tended to lean toward the "positive" side as she felt that "things get better as you get older". The women in her life that she saw as role models were older than she and she felt that they received more respect because of their age. She also felt that she

"deserved the grey hair now" that she had achieved her educational goal. One 47 year old woman from the MIW who expressed "mixed" feelings tended to lean toward the "negative" side. She said she had mixed feelings about growing older and that she had a hard time coping with turning 40. Her feelings related to not wanting to be dependent as her mother-in-law is presently. The biggest change for her has been emotional e.g. mood swings. The family handles this fairly well although her husband sometimes has a hard time as she is usually the supportive one. While he tries to understand, he tends to react rather than understand.

In summary, the majority of women from the MIW expressed negative feelings toward the menopausal experience. These negative feelings related to fear of aging and the unknown, anger at themselves, families and physicians, and concern regarding physicians' attitudes towards their bodies. Actual physical pain also prompted negative feelings. In contrast to the MIW group, the majority of women from the Alumnae expressed positive feelings towards the menopausal experience. These positive feelings related to their feeling better physically and emotionally, relief because of being unable to conceive, and the fact that menopause is a normal process.

Kinds of Information Useful to Climacteric Women

Women from both the MIW and the Alumnae were asked about the kinds of health information that would be useful to them as a

woman at this time in life. The majority of women interviewed from the MIW said they wanted information about the physical aspects/physiology of menopause. They wanted to know how the various "symptoms" related to the physiology of menopause; "what happens to a woman's body when we go through menopause"; "what symptoms to expect"; "what changes take place in the body"; and "knowing the signs and symptoms of menopause". The majority of women from the Alumnae also felt it was important to know about the physical/emotional aspects or changes related to menopause. They said that "basic information about the physical aspects of menopause"; "knowing what the menopausal symptoms are"; and "information about changes that are possible and may occur" were important to know.

The majority of women from the MIW wanted information on the use of HRT. They wanted to know about the "pros and cons of estrogen". Some of the women were fearful of estrogen because they had experienced problems when taking birth control pills. As one woman said, it was important to have information so "you don't get caught in the estrogen therapy trap". She had been on estrogen seven years ago and thought she was having a stroke because she had such severe migraine headaches. During these headaches, there were times when she could not see for three hours. She later found out that she was allergic to estrogen and her neurologist told her that if she took estrogen again she would be blind or dead. Some of the women were also concerned about estrogen because of the increased risks related to cancer;

one of these women was on HRT and had a family history of cancer; the other woman's physician had recommended "hormones" to her but she had been reluctant to take them because of her fibrocystic breast disease. In sharp contrast to the MIW group, none of the women from the Alumnae identified information about HRT as being useful to them.

Talking with other women about menopause was mentioned as being useful by the majority of women from the MIW. They wanted to "hear what other women are experiencing"; you "need to know you're not alone"; "women need to be talking about it (menopause)"; and "talking with other women reassures you that it's part of the aging process". Some of these women specifically suggested that a menopause support group be established. On the other hand, only one woman from the Alumnae said that knowing the experiences of other women would be useful.

A few women from the MIW identified information about nutrition as being useful to them e.g. information about general nutrition and the pre-menstrual syndrome diet. One woman from the Alumnae mentioned that information on nutrition and osteoporosis would be useful.

Two women from the MIW specifically mentioned information relating to family dynamics as being important. One of the women commented that "the family needs to understand where mother is coming from". She said that in their family they discuss things quite readily but there is some hesitance in talking about menopause. The second woman said that "mood changes can be hard

on family and they need to understand". None of the women from the Alumnae group identified family understanding as being important. A few of the women from the Alumnae commented on the "normal" aspect of menopause. Because menopause is such a varied experience, they felt that women need to know what is normal and understand that it is part of the life cycle.

A few women from the Alumnae group mentioned the importance of a positive self-concept. Menopause should not mean "you're sick or unattractive". During menopause one needs "to feel you're not useless as society often sees you this way".

Several individual comments were made by the group of women from the MIW about health information that would be useful. One woman identified several facts about hot flashes that she felt were important: women need to know what triggers them, how to cope with them, that they do not raise core temperature and that one is not sick. This particular woman felt that women needed information about menopause in their late thirties or early forties. One woman said that women need to know the "psychological things you'll go through", that it is normal and doctors "need to know more about menopause so you're not sent for brain scans or put on drugs, etc.". She felt that information about the menopause should be taught in school so that it would be seen as a "normal" life event. One woman identified that more scientific information was needed about osteoporosis. She described a workshop she had attended where an exercise physiologist had said HRT was the answer to osteoporosis for the

post-menopausal woman. She had rejected this position outright but it had taken her aback. One woman commented that one should prepare for menopause when they are having their children and that much of this preparation could take place in the doctor's office. One woman mentioned that the "wholeness of mind and body" needed to be addressed at this time of life. Another woman felt that information about exercise, rest and relaxation to decrease stress was important. She added that if she had received information about menopause earlier, she "probably wouldn't have had tests done". This particular woman had had an EEG and a CT Scan done because of numbness in her head.

Several individual comments were also made by Alumnae members in relation to information that would be useful to climacteric women. For example, one woman identified information on the "importance of motivation and being interested in life" as being useful. Her experience was that she sometimes had "to psyche herself into doing things". She also felt that adjustment to children leaving home and changes in sexual relations were important areas of information. She believed that clinics for women who are "having the same problems" should be available.

Another woman from the Alumnae identified the importance of being prepared for surgery if required. She could not understand why both her ovaries had to be removed when the cyst was only on one. "Both doctors and nurses felt it didn't matter as I was 48 but it did matter to me". The doctor did not explain why he "routinely took both ovaries out" and she "resented this a lot".

Other topics of health information that the Alumnae mentioned were information on measures to reduce the severity of symptoms and knowing the length of time symptoms can be experienced. One woman did not identify any information that would be useful to her. She felt that she knew about menopause because of her nursing background.

Table 7 illustrates the kinds of information women would find useful to them at this stage of life.

TABLE 7

Kinds of Information Useful to Climacteric Women as Identified by the MIW and Alumnae Groups

INFORMATION	MIW GROUP (n=11)	ALUMNAE GROUP (n=7)	TOTAL GROUP (n=18)
Physical Aspects/ Physiology of Menopause	7	4	11
Use of HRT	6	0	6
Experiences of Other Women	6	1	7
Nutrition	3	1	4
Family Understanding re: Menopause	2	0	2
Changes that are Normal	0	2	2
Importance of Positive Self-concept	0	2	2
Other	5	5	10

In summary, the majority of women in both groups clearly wanted information on the physical aspects/physiology of menopause. The majority of women from the MIW also wanted information on HRT while none of the women from the Alumnae wanted this information. As well, only one woman from the Alumnae wanted to hear about the experiences of other women while the majority of women from the MIW wanted this kind of information. The women from the Alumnae group identified information about what menopausal changes are normal and positive self-concept as being important. The information presented at the MIW may have influenced the responses of the MIW women to this particular question.

Stimuli for Seeking Information/Not Seeking Information

Women from the MIW group were asked to identify what prompted them to seek information about menopause and more specifically, what prompted them to attend the MIW. One of the main reasons for information seeking was because women said they had inadequate or little information about HRT. The need for information about HRT was precipitated by hormonal imbalance manifested by hot flashes and/or night sweats. These women were either on HRT, had taken estrogen in the past or had had HRT recommended to them. For example, one woman had been to her doctor because of severe hot flashes. He had recommended hormones but she was reluctant to take them because she has

fibrocystic breast disease. She came to the workshop to learn more about hormones.

Another major reason why women came to the workshop was because they had inadequate and/or little general information about menopause. One of the women said she did not want to buy a number of books to get the necessary general information. She recognized that she was perhaps "a bit lazy" but felt that the MIW would give her all the information she needed. Another woman whose doctor had been unable to tell her much about menopause had referred her to the MIW. She was particularly interested in knowing "if her period could start again" once it had stopped.

A third important reason why women went to the workshop was because they wanted to hear about other women's experiences with menopause. By hearing what other women had to say about their menopausal experiences, they hoped to gain support from knowing that other women were experiencing similar changes. For example, one woman mentioned that she had gone to see a doctor as she was "stretched out". She had missed one period, had moved to a different home and her two grown sons had moved out of the house. The doctor gave her tranquilizers and told her to see a psychiatrist. She took one tranquilizer and quit because she decided this was against her "total philosophy". She "needed to talk to other women" and because she had no family in Canada, she came to the MIW.

The women made several individual comments as to why they had attended the MIW. One woman to whom surgery had been

recommended wanted a second opinion; another wanted to know if other women were experiencing moodiness and irritability; another said her "symptoms" were becoming more severe and her family was complaining; another wanted to know if her depression was due to her marriage breakdown or menopause.

Women heard about the workshop in several ways. One read about the MIW in the newspaper, two had been told by a friend, one saw a notice about the MIW in the WHC newsletter, one saw it advertised at the Fort Garry Women's Resource Centre, one was referred by her doctor and one heard through her sister.

The women from the Alumnae group who had felt a need to look for information regarding menopause were able to identify the stimuli for their search. For example, one woman said it was her surgery (hysterectomy and bilateral oophorectomy) which really caused her to seek information. She particularly wanted information on hot flashes and estrogen as she needed to decide whether or not she should take estrogen. "That was a hard one" (decision) as she thought she would only delay menopause. She decided against estrogen but in hindsight, felt she should have taken low doses. Before surgery, she "blamed a lot on menopause rather than the ovarian cyst". The second woman who was soon to be 50 and had no change in her menstrual cycle was asking for information because she thought she should have some signs of menopause. The last time she had seen her doctor she had asked "Shouldn't I be having hot flushes or stopping my periods?" She thought she was not fitting into the "normal parameters".

The majority of women from the Alumnae responded that they had not had a need to look for information about menopause. The main reason for not looking was the fact that menopause was not posing any problems for them. They saw their menopausal changes as normal, and they felt healthy.

Some of the women from the Alumnae group also identified their nursing background as an advantage as "nurses have a knowledge base". This was another reason for not needing to look for information regarding menopause. It was interesting to note that most of the nurses did not recall studying menopause during their nursing program. Closely aligned to the nurse's knowledge base is the fact that nurses have access to medical/nursing information. Two Alumnae members cited this in their responses. Both of these women had nursing journals coming into their homes.

Some of the Alumnae women who had not looked for information mentioned that they were very busy at home and at work and did not have time to do much reading about menopause although they said they would read information that "came across the desk" or "crosses my eyes". One woman said her doctor had kept her informed about menopause. She also felt that information was more readily available now than years ago.

In summary, the major stimuli for women from the MIW group to seek information were inadequate and/or little information about HRT, inadequate and/or little general information about menopause, and wanting to hear about other women's experiences with menopause. The stimuli for Alumnae women to seek

information were impending hysterectomy and bilateral oophorectomy and a need to determine the normal parameters of menopause. Women from the Alumnae who had not searched for information said the main reason for not searching was because menopause was not posing any problems for them. Their nursing background, access to medical/nursing literature, and busy schedules were other reasons for not seeking information.

Extent and Method of Search

Women from the MIW were asked where they had looked for information besides attending the workshop (MIW). The majority of women indicated they had looked for information in bookstores and libraries. A few had gone to the doctor; looked in pamphlets; looked in medical/nursing/sociology journals and various women's magazines and newsletters, and listened to a radio program on menopause.

The women from the Alumnae who had looked for information had done so in a variety of places. One of the women had written to Janine O'Leary Cobb, founder and editor of A Friend Indeed, a monthly newsletter for women in the prime of life. She had also talked to peers (other nurses), her family doctor, read "popular" articles and gone to both the public and university libraries. The other woman had looked for information by contacting her mother, aunt, friends and colleagues.

The women from the MIW group were also asked what information they were able to find outside of the workshop. Less

than half of the women mentioned that they had either not found what they were searching for or were not satisfied with what they had found. For example, one woman who had looked for information in the library was not sure if she "had good information or not". She did not feel "confident" in the material she was reading and consequently did not read the material thoroughly or absorb it.

Slightly more than half of the women who had looked for information outside of the MIW were able to find some. Some of the women who had gained their information through reading found that they were "normal" and that menopause was a stage in the life cycle. Other information the women found included the pros and cons of estrogen therapy, the concern for osteoporosis and that HRT could alleviate osteoporosis, and confirmation that they were menopausal and did not have a medical problem.

The information the women from the Alumnae were able to find varied. One woman said she found that there are "individual differences in women" in relation to menopause. The other woman said she was able to find only partial answers to her questions as the information "wasn't that great".

Women from the MIW group were also asked how often they had looked for information. Fewer than half said they had searched twice; all included the MIW as "one" of the searches. The "other" search included going to the library, seeing a gynecologist, reading a pamphlet and seeing the family doctor. Some women could not identify exactly how often they had looked for information; one said she searches "often"; one was not aware

of how often as she had not gone out of her way to look; one woman read information "as it went by" but did not specifically search out information on menopause. One woman said that in the last six months she has looked the most - "once a week in formal and informal ways". One woman said she was always looking for information when she went into bookstores; she had made a focused search, however, when she contacted her doctor, friend, aunt and gone to the library. A few women did not comment on how often they had searched for information.

One of the women from the Alumnae who had searched for information said she had looked "informally about four times in the last year". The other woman was unable to identify how often she had searched for information. She did say, however, that she had looked "more often the first year after surgery (hysterectomy and bilateral oophorectomy) as the flashes exhausted her".

The women from the MIW were asked what particular people they had contacted for information on menopause. The majority of women said they had contacted either their family doctor or gynecologist. Doctors tended not to be seen as a good source of information even though women contacted them. Women found that there "wasn't much information-giving in the doctor's office as you are rushed" or the doctor thought they were "too young to go through menopause". They also said "doctors don't discuss". For example, one woman had had an experience in which her doctor had given her Progesterone without any instructions regarding its use. She had bled profusely and when she returned to the

doctor's office he said she needed a hysterectomy. Other women found that doctors lectured them or prescribed interventions that they did not believe in e.g. tranquilizers.

A majority of the women from the MIW said they had contacted other women for information about menopause. The women who were contacted were friends, sisters, aunts and co-workers.

The women from the Alumnae group who had looked for information also contacted particular people for information. These people included the family doctor, Janine O'Leary Cobb, a mother, an aunt, a sister, friends and colleagues.

In summary, the main places where the majority of women from both groups had looked for information were bookstores and libraries. Some helpful information was found in these places by a slight majority of the women. The person contacted the most by both groups was the physician. Physicians, however, were not seen as good sources of information. Other women were contacted for information by a majority of both groups, although other women were not contacted as frequently as physicians. The frequency of the searches for information varied for both groups from "twice" to "often". The majority of women from the Alumnae group had not searched for information at all.

Problems Encountered during the Search

When women from the MIW were asked if they had encountered any problems or difficulties in looking for information, the majority of women answered "yes". All but one of the women who

had encountered problems identified lack of information or availability of information as the main concern. For example, one woman, a nurse, said that nursing journals were a disappointment as they had no information about menopause. Some women felt there was not enough sharing of information among women, one said this in relation to the MIW and one in relation to women in general. Some expressed problems in relation to their doctors. For example, one woman said doctors were not listening or understanding while another woman said she had asked her doctor for information and had received nothing because the doctor said there was little information available. Those women from the MIW who had not encountered any problems or difficulties felt they had access to the information they needed.

The two women from the Alumnae who had searched for information also voiced some problems or difficulties. One Alumnae member said there was not enough information available and that there was a "tendency to deny the biological element in the psychology literature." The other Alumnae member said there was not a lot of good information written for women on menopause, lots of articles on sexuality and being attractive but not on menopause.

In summary, the main problem encountered by both groups in looking for information was the lack of information about menopause or the unavailability of the information. Other problems encountered by the MIW group related to inadequate

sharing of information among women and a lack of understanding and information-giving on the part of physicians.

Positive Experiences during the Search

When women from the MIW were asked what positive experiences they had had in looking for information, the majority of the women said the workshop (the MIW) had been a positive experience. Those who found the workshop positive appreciated "women coming together and sharing their experiences". For others, it cleared up misinformation. For example, one woman said it took a weight off her shoulders to learn that the "empty nest syndrome" is no longer operant. She had been feeling "thank goodness the kids are gone" and had been feeling guilty about that until she went to the workshop. Another woman thought that sex was over once menopause arrived until she went to the workshop. For another woman, the workshop helped her make a decision about estrogen therapy. She decided not to take estrogen and will tell her doctor of her decision next time she sees him.

Some of the women from the MIW cited experiences other than the workshop that had been positive for them. One of the women said she found reading about estrogen and taking estrogen helpful for her. Another woman cited the support and listening from her family doctor as positive. Knowing what to expect regarding body changes had helped one woman feel normal and this had been a positive experience for her. Another of the women said that receiving the package of information on menopause from the WHC in

the mail (about a year prior to the MIW) had been positive for her.

The women from the Alumnae who had searched for information had encountered positive experiences. One woman said that her doctor, friends and colleagues had been very supportive. Another woman said the information she had received from Janine O'Leary Cobb about menopause was "very good" and this had been a positive experience for her.

In summary, the majority of women from the MIW had encountered positive experiences during their information search, the positive experience for them being the workshop (the MIW). The women from the Alumnae had also had positive experiences, these being the giving of personal support and the receiving of specific information about menopause.

Factors Pertaining to Evaluation of Information

Women from the MIW were asked how they knew when information was helpful or useful to them. The majority of the women responded to this question by saying when the information related to them or could be related to their experiences. For example, one woman said information was helpful when "it confirms what I'm feeling deep down inside". When her doctor said she was not "psychologically prepared" for possible surgery (hysterectomy and oophorectomy), it confirmed her feelings regarding the surgery.

Some women commented that information was useful if it "has the appearance of scientific validity" or is "backed-up by

research". The source of the information was important to them.

Other responses were received from the MIW women in relation to information and when it is useful. These women said information was helpful if it was "up-to-date" and pointed out the "pros and cons so one can make a judgment". They also felt it was helpful if it was factual and in-depth, "fits with what you already know", and relieves anxiety.

The women from the Alumnae who had searched for information were also asked how they knew when information was useful or helpful. One woman said that information was useful if it answered your questions. She added that information was not useful if she did not believe the person who was giving her the information. For example, she did not believe her gynecologist when he said her hot flashes would only last six months. She said she had some "prejudice against men because they haven't experienced menopause or childbirth". The second woman said that information was helpful if it reassured you and decreased worry. She added that sometimes information can be confusing if it is not clear.

In summary, women from the MIW felt that information about menopause was helpful or useful if it could be related to them or their experiences. Women from the Alumnae felt that information was helpful or useful if it answered one's questions, provided reassurance and decreased worry.

Factors Involved in Continuing or Stopping the Search for Information

Women from the MIW were asked how further information seeking was affected by finding helpful or useful information. Slightly more than half of the women said that they stopped looking either permanently or temporarily when they found useful information. For example, one woman said it "alleviates temporarily the need to pursue, allows you to absorb and feel confident but then go on"; others felt no need to pursue further. Slightly less than half of the women said they went on with their search whether or not information was useful or helpful. As one woman said, she would always read about menopause as anything that has the word menopause attached to it is "like a neon light". She said she would want to know if there is any new information and more specific information about nutrition and calcium supplements.

The women from the Alumnae who had searched for information were also affected by finding helpful or not helpful information. For example, one of the women said when information was helpful, she kept looking but not as actively; if information was not helpful, she looked further but with some pessimism. In fact, she had seen the MIW advertised but felt at that point she no longer needed the information.

When the women from the MIW were asked if there were other factors which prompted them to continue searching or to stop, the majority of the women said "yes". Those factors which prompted

women to continue their search were the perception of menopause as a "constant stimulus", wanting to have the most current information, and the perceived benefits of talking with other women about menopause. Those factors which prompted women to stop their search permanently or temporarily were fear, family attitude, their own attitude e.g. "ignorance is bliss", laziness, the need to make a decision e.g. to take HRT or not, and the knowledge that menopause is a fact of life.

The women from the Alumnae who had searched for information also identified other factors that had prompted them to continue or stop searching. For example, one woman said she had stopped looking for now but would seek more information if changes in her body were more intense than they should be. Another Alumnae member said she would keep looking because she is interested in women's issues and because she has two daughters. She couldn't talk with her own mother about these things but she can with her own daughters.

In summary, finding useful or helpful information about menopause tended to temporarily or permanently stop the search although many women went on with their search whether or not information was useful or helpful. Women from both groups identified other factors that prompted them to continue or stop their search e.g. the perception of menopause as a constant stimulus, family attitude.

Changes Made in Life/Lifestyle

Women from the MIW were asked about the changes, if any, they had made in their life/lifestyle as a result of the health information they had acquired. All but two of the women had made some changes. Some of the changes made were based on information from the MIW; some on information from other sources. The greatest number of comments pertained to the topic of nutrition in general and Calcium in particular. Some of the women commented that they were taking Calcium supplements; two had started Calcium before the workshop based on their own reading and one had started following the workshop. Regarding general nutrition, women were trying to eat more nutritious meals, omit certain foods e.g. sugar, include more foods rich in Calcium and eat smaller, more frequent meals.

A majority of the women commented about exercise in relation to changes that had been made in their life or lifestyle. For example, some women were now walking, swimming, doing the 5BX program, running, using the exercise bike and downhill skiing.

Slightly fewer than half of the MIW women identified "psychological" changes that they had made or were trying to make. For example, one of the women said she tries to eliminate stressors she has control over e.g. "not loading my plate with too many things". Another woman said she is learning to say "no" to some people. One woman who was separated from her husband was attending a support group to help her deal with her marriage breakdown. Another woman identified that their family has

changed their relationships with respect to expectations of different family members. This seems to be helping her daughters prepare for life's stages and she finds she is sharing some of her experiences with them for their benefit. One woman mentioned that she tries not to "get upset over simple things" and to be more relaxed.

Several women specifically mentioned they avoided coffee or had decreased their coffee intake. One woman said she drank no alcohol and another woman avoided "pop".

A few women commented specifically on rest and sleep. They said they try to get a good night's sleep and one said she rests during the day if necessary.

Two women from the MIW group said their decision not to take estrogen was finalized as a result of their attendance at the workshop.

A few women identified changes that they intended to make in the future as a result of information they had received. One woman has plans to quit smoking as she knows she is at increased risk for osteoporosis because of this and her previous lack of exercise. Another woman has plans to start relaxation exercises as she gets "uptight".

One woman identified some of the factors that pose problems for her in relation to nutrition and exercise. She mentioned that she was never a milk-drinker because she has always hated milk. Because she is single and lives alone, she eats when she is hungry so there is no incentive for her to have three meals a

day. She said she realizes she needs to exercise but always puts it off until tomorrow. She was well aware of her increased risk for osteoporosis because of these factors and because she is thin with little adipose tissue.

The two women from the Alumnae group who had been looking for information were also asked what changes they had made in their life/lifestyle as a result of the information they had acquired. One of the women said she had quit smoking at menopause because of the increased risk of heart disease after menopause. She had also started swimming and walking. The second woman said she decided not to work full-time any longer. She had made this decision because she was close to 50 and thought she wouldn't push herself too much but rather "enjoy a few things". She added that at this age you "look at how much time is left to your life and what you're going to do; you tend to become more reflective".

In summary, the majority of women from the MIW as well as the women from the Alumnae who were seeking information had made changes in their lifestyle. Some of these changes were made on the basis of information received at the MIW; some on the basis of information from other sources. The greatest number of changes were made in the areas of nutrition, exercise and psychological stressors.

Greatest Problem/Concern/Worry

Women from the MIW were asked to describe their greatest problem/concern/worry facing them at this time in their lives and what could alleviate it. All but one of the women acknowledged that they had problems/concerns/worries. The main concerns related to marital and financial problems, fear of cancer and children growing up and leaving home.

Those women who cited marital problems as concerns were at different stages in their marriage. One of these women was still in her marriage; one was "getting over the marriage". One was thinking about getting counselling, the other woman was receiving counselling.

Financial concerns were voiced by a few of the women from the MIW. One of the women, who is separated, thought the situation might be alleviated if her daughter who is going to university got a job. The second woman who was 57 said she and her husband had financial concerns because they are both close to retirement. She commented that so often women are widowed without means. She and her husband had recently seen a financial counsellor in this regard.

A few of the women expressed fears in relation to cancer; one because of a family history of cancer and one because she has fibrocystic breast disease. The woman with a family history of cancer felt this fear would be alleviated once she came off HRT. The woman with fibrocystic breast disease is being monitored very

closely but she said it is very "distressing to have cysts drained every 3-4 months."

A few women expressed concerns regarding children. One said she was needing to deal with children leaving home. She had mixed feelings about this as it was "hard to let go" and yet she was looking forward to being on her own. One said she hoped that her two sons would grow up to be good citizens. These were considered by the women as normal, developmental concerns.

Several individual problems/concerns/worries were also expressed by the women from the MIW. One woman feared further surgery for endometriosis and was concerned with all the hormones she had taken. One doctor had said they (the hormones) could "shut down my pituitary". She further added that her hysterectomy had made her look at her femininity and the fact that she had not had children. In relation to her hysterectomy, she still had a problem with the fact that friends, family and nurses would not talk with her about what had happened to her. A nurse herself, she said that in future, she "will emphasize the finer points in nursing". She said that nurses need to be better informed particularly in relation to the emotional aspects of care. When she was hospitalized, the doctors warned her of hot flashes and one nurse warned her about "crying jags" after hysterectomy.

Another woman from the MIW who was taking estrogen and provera (HRT), hoped that it (the HRT) would "work out" and was worried that it would not. One woman who had stopped seeing her

gynecologist because he had put her on HRT, was concerned about finding suitable medical care and hoped that she would not "have to shop around". Another woman identified that she was "at a crossroads in her career"; she had committed herself to a non-academic life but was not sure if that was right for her. One woman mentioned concerns related to her mother-in-law who was very dependent on her and very difficult at times. She felt that if her mother-in-law were more involved in activities e.g. senior's centre, the situation would be alleviated.

The one woman from the MIW who mentioned no problems/concerns/worries described herself as a relaxed person. Because she was close to 50, she wanted to do more things and "get the most out of life". She said that she is more daring and takes more risks e.g. recently took up downhill skiing. She felt she deserves to have more out of life as she has devoted many years to home and family and now some time is needed for her.

When all the women from the Alumnae group were asked about their greatest problem/concern/worry, the majority commented that they had some. A few of the women said they were concerned over elderly parents. A few mentioned concern over their husbands' future retirement and how they as couples would adjust to it. One woman indicated that she would like to continue working even though her husband retires. She wondered how that might work but was confident they could handle it as they had been through so many crises already. One woman, whose husband had already retired, thought she should quit work when he did. Her husband

has adjusted very positively to retirement but she thinks she would like to return to work as she gets a lot of "self-satisfaction" from nursing. Her husband is supportive of her return to work.

Other individual concerns were expressed by Alumnae members. For example, one woman was concerned over "what's in store for my children", e.g. what impact AIDS will have on their lives. Another woman's biggest concern/worry was her sister who "has a lot of problems". She felt the only way these could be alleviated was through her giving her sister support and helping her as much as possible. One woman mentioned her very busy life as a concern. She said "There usually isn't enough of me to go around". Going back to work had helped to alleviate this situation somewhat as she said she really enjoys her work and the people at work.

Two women from the Alumnae commented that they had no real concerns or problems. One of these women felt their family was quite fortunate right now as everyone was healthy, including her mother, and they had children and grandchildren. She felt it was a good age because their family was grown-up and she and her husband could be independent.

In summary, the MIW women expressed more problems and concerns than the Alumnae group. Their concerns related mainly to marital and financial problems, fear of cancer and worries about children. The Alumnae women's concerns related to retirement and elderly parents.

Table 8 presents the identified problems/concerns/worries for the two groups of women.

TABLE 8

Greatest Problem/Concern/Worry as Identified by the MIW and Alumnae Groups

PROBLEM/CONCERN/WORRY	MIW GROUP (n=11)	ALUMNAE GROUP (n=7)	TOTAL GROUP (n=18)
NO	1	2	3
YES	10	5	15
TYPE			
Marital Problems	2	0	2
Financial Concerns	2	0	2
Fear of Cancer	2	0	2
Concern re: Children	2	1	3
Retirement	0	2	2
Concern re: Elderly Parents	0	2	2
Other	5	2	7

Other Comments

When women from the MIW were asked if they had any other comments, a few women did comment. One woman mentioned again that she had enjoyed the workshop and had felt great relief when she heard about breast changes related to menopause. She felt, however, that her doctor should have informed her about this. Another woman said she is pleased that "people are addressing the area of menopause". She was concerned, however, that it was

taking the initiative of women to seek information that was not readily available. Another woman commented on the importance of getting information early before "you're into menopause" so you know that it is normal.

All but one of the women from the Alumnae made additional comments. One woman said "the more information you can get across about menopause, the better". She felt that men should be included in the information giving as many men are ill-informed. She did not include her own husband as he has always been very supportive, always believed in her and taken her seriously. Another woman from the Alumnae thought that "if women are aware of things and have a healthy attitude, it makes menopause easier". She felt that women could blame a lot of things on menopause. Being at work had helped to take her mind off herself and made her thankful for what she had. One woman felt that women do not fear menopause as much now because they are better educated. She also felt that most women carry on with their daily life. She recognized that some women have "bad hot flashes" and that it must be very unpleasant for them. Another woman felt this was a "good time of life" with much to look forward to. One woman said she tends not to dwell on menopause when there are no symptoms. Another woman commented that "If one can feel in control, it makes one feel better and more worthy".

The additional comments received from both groups of women serve to reinforce the importance of information to women in the climacteric.

In summary, the findings described the menopausal changes and feelings of the women from both the MIW and Alumnae groups. The information search process of those women seeking information was also described.

Limitations of the Study

There are several methodological limitations which need to be considered when interpreting data from this study. They are as follows:

1. small sample size. It is difficult to determine if the description of the information search process in climacteric women is truly reflective of women in general given that the sample sizes were small e.g. 11 women from the MIW and 7 from the Alumnae volunteered to participate in the study.

2. sampling biases. The samples are not representative of the general population in relation to several variables. For example, both groups of women were well educated, particularly the Alumnae group where a diploma from a nursing school is the minimum level of education, and middle class, with the lower socio-economic groups of women not represented at all.

The fact that the Alumnae group is comprised solely of nurses could influence search behaviors in that they may already have the requisite knowledge. Access to medical/nursing information on the part of nurses could also contribute to their perception that they had no need to look for information.

3. use of volunteers. When using volunteers as in this study, there is always the inherent possibility that data will be polarized and not truly reflect what generally tends to occur. For example, only those women who felt comfortable enough to talk about their experiences may have volunteered to participate.

4. reliance on subject recall of past experiences. Inability to recall past information seeking behaviors may lead to under-reporting of these behaviors thereby skewing the results of the study. In an attempt to overcome the negative effects of recall, women who attended the MIW were interviewed as soon as possible following the workshop. With the Alumnae group, no control could be exerted over the span of time between the information search behaviors and the interview. Prospective study with accurate record keeping regarding menopausal changes and the information search process would be advantageous.

5. placement of the Menopause Attitude Scale (MAS). Having the interview prior to the completion of the MAS may have had some effect, either positive or negative, on the MAS score.

6. attendance at the MIW. The information received at the workshop may have influenced the responses of the MIW group.

Chapter VI

DISCUSSION

Discussion of the Research Questions

The findings of the study will be discussed in relation to the literature review, the conceptual framework and the identified research questions.

Stimulus to Engage in Information Search Process

As the findings indicate, the two major stimuli for seeking information were inadequate or little information about HRT and inadequate or little information about menopause in general. The third major stimulus was wanting to hear about other women's experiences during the climacteric. Lenz (1984), in describing the information search process, notes that stimuli may arise from within the person or from the external environment. For the majority of women seeking information, both from the MIW and the Alumnae, there was a combination of internal and external stimuli that had prompted them to engage in the search process. For example, those women who recognized they had inadequate knowledge of HRT had experienced hormonal imbalances manifested by hot flashes and/or night sweats. These were internal stimuli that tended to send women to consult with their physician who often responded with a recommendation of HRT. At that point, the physician's response to the woman's behaviors became an external stimulus for continued search behaviors. These data serve to emphasize, in part, the multi-dimensional aspects of the

information search process, for example, search behaviors stimulating further searching.

As noted in the data, many women in this study who were searching for information were not satisfied with the information they received from their physicians. This finding is consistent with Lenz's (1984) work whereby she noted that clients often perceive themselves to be unsuccessful in obtaining the information they want from health professionals. Webb (1986) also found in her study of women undergoing hysterectomy that lack of information from the hospital staff was one of the most unsatisfactory aspects of the experience.

The dissatisfaction the women expressed in relation to the information received from the physician may have been because the information was insufficient in amount or because they were given information they did not want to hear. As discussed in the literature review, there is considerable pressure for physicians to prescribe HRT for women of menopausal age (Lufkin et al, 1988; Ross et al, 1988). While only two women from the MIW were currently taking HRT, others had had hormones recommended to them. Of the two women taking HRT, one woman had been pressured by her gynecologist to take it even though her menopausal changes were very slight. The considerable controversy over the risks and benefits of HRT in both lay and professional literature (Barrett-Connor, 1987; Budoff, 1984; Cobb, 1988; Gambrell, 1986), may have added further to this dissatisfaction. For example, if women read about the risks of HRT and then have it prescribed by

their physician, this might precipitate fears and doubts that would lead to dissatisfaction with the care their physician prescribes.

Women in this study did tend to be somewhat fearful regarding the use of hormones and did not take their use lightly. This finding is consistent with that of Kaufert (1986) who found a certain reluctance among women to take estrogen because of its link with endometrial cancer and because of a general fear of hormones based on their past experiences with hormones e.g. oral contraceptives. The particular woman in this study who was pressured by her gynecologist to use HRT had a history of cancer in her family. This family history of cancer made her fearful of continuing with the HRT. Another woman to whom HRT had been recommended was fearful because she had fibrocystic breast disease. Jick et al (1986) in their study provide some grounds for this fear in that they discovered a positive association between estrogen use and hospitalization for fibrocystic breast disease. Another woman in this study was fearful of estrogen as she had developed an allergic reaction to the drug and subsequently suffered from very severe migraine headaches.

The surgical experience (hysterectomy and oophorectomy) was also a powerful stimulus for a few of the women in the study to engage in further information seeking behaviors. For these women, none could identify why a bilateral oophorectomy was being performed. This finding is consistent with the medical literature where the rationale for oophorectomy is not clear

(Anderson et al, 1987), often being performed because there is indication for a hysterectomy and because the woman is over 40 years of age.

As indicated in the findings, women in this study did experience a number of different physiological changes, internal stimuli, that were attributed to menopause. Initially, however, these changes were not always recognized as being menopausal in nature e.g. numbness in head. A pervading stimulus for the women became the need to determine that what they were experiencing was "normal" and not abnormal or pathological in nature. This need to determine the normality of their changes appeared to be an underlying factor in women wanting general information about menopause and in wanting to hear about other women's experiences with menopause. It was a way of measuring themselves against the facts found in textbooks and against the experiences of other women.

The women from the Alumnae who had not looked for information said they had not done so because the menopausal experience was "normal" for them and not posing any problems. Secondly, they felt they had sufficient information because of their nursing background and their access to this type of information. Lenz (1984) points out that "the degree of importance the individual attaches to the situation and the degree of uncertainty and risk associated with it" (p. 62) are aspects of the stimulus that affect subsequent steps in the search process. Nurses, by virtue of their knowledge base or

access to knowledge, have greater means by which to normalize the menopausal experience and thereby reduce the importance, risk and uncertainty attached to menopause as a stimulus. The severity of the menopausal changes, however, would seem to be the overriding factor in that those women who were looking for information were having problems with menopause, whether they were nurses or not. For example, two nurses were in attendance at the MIW and two nurses from the Alumnae group were looking for information.

Two important variables which also seemed to play a role in initiation of the information search process were age and menopausal status. The women seeking information tended to be younger, were peri-menopausal, and perceived themselves to be just beginning or in the middle of the menopause. This was in contrast to the women from the Alumnae group who were older, post-menopausal and perceived themselves to be in the middle or finished with menopause. One could perhaps hypothesize that women who are just beginning to experience menopausal changes are more inclined to seek information to validate the normality of their changes compared to those women who are further into the climacteric and have already done this. Furthermore, the women who were peri-menopausal were experiencing a greater number of menopausal changes than the Alumnae group. In fact, many of the Alumnae women commented that their menopausal changes were less intense than previously, reflecting their post-menopausal status.

Information Useful to Climacteric Women

The second step of the information search process is information goal setting which may or may not take place as part of the search process. Part of goal setting includes determining the kind of information that is desired. The kinds of information that women from the MIW wanted related directly to the stimuli for initiating a search. The majority of women clearly wanted information on the physical aspects of menopause, HRT and the experiences of other women. The women from the Alumnae who had searched for information wanted information on the physical and emotional aspects of menopause so that they would know what was normal. Women were well able to define the kinds of information they wanted.

Undoubtedly, this category of goal setting has been influenced by the information on menopause in the popular literature and that received from the MIW. In turn, the issues and controversies that exist in information regarding menopause have probably resulted in some of the goal setting that the women in the study did.

Extent and Method of Search

Once a woman reached a decision to search actively for information on menopause/climacteric, various search behaviors were initiated. Lenz (1984) defines the extent of the search as "the total number of activities carried out" and the method of search, the information sources tapped (p.63). While studies indicate that personal sources of information are preferred to

impersonal ones, impersonal sources of information should not be discounted (Lenz, 1984). This fact was borne out by the data which indicated that all but two (2) of the women who had searched for information, from both groups, had used impersonal sources of information. The impersonal sources cited were bookstores, libraries, journals and pamphlets; all had used personal sources of information, namely physicians and other women. In addition to physicians and other women, the personal sources of support and understanding that women in Kaufert's (1980) study mentioned were husbands, children, friends and people at work. While data related to sources of support were not specifically collected in this study, only women from the Alumnae who were seeking information mentioned sources of personal support e.g. husband, friends, colleagues.

For the majority of women in this study who had searched for information, their physician had been a key personal source of information. Physicians, however, were not seen as good sources of information because of limited or incorrect information-giving or inaccurate assessment of the women's physiological or psychological status. This is consistent with the findings of Lenz (1984) in which attempts by clients to consult with physicians and nurses were thwarted because of "time pressures, lack of privacy or professional attitudes, and norms regarding information giving" (p. 64). This is also consistent with Kaufert's study (1980) in which she found that only two-fifths of the women mentioned the understanding and help provided by a

physician. Of interest is the observation that no nurses were contacted for information, substantiating Lenz's observations regarding the difficulties clients have in consulting with health professionals. One factor, however, which may prevent women from contacting nurses is the fact that most nurses are not readily available outside of the traditional health care system. Increased movement toward independent practice for nurses may well change this situation.

The MIW, a personal source of information, was perceived positively by the women who attended because women were able to share their experiences, obtain new information and have misinformation corrected. Impersonal sources of information e.g. books, pamphlets, were moderately helpful in establishing normal menopausal parameters and discussing estrogen therapy. Both personal and impersonal sources of information were utilized by a majority of the women in the study. This is consistent with the philosophy of the women's health movement in which both written information is made available as well as opportunities for sharing among women (Boston Women's Health Book Collective, 1985; Cobb, 1988; Voda, 1984).

The extent of the search or level of search activity for the majority of women was not high e.g. the mode for number of searches made by the women seeking information was two. The MIW was included as one of the two searches, generally coming after contact with a physician. The effectiveness of the MIW would seem to have curtailed search activities to some extent. Several

women mentioned that they had stopped their search temporarily or permanently because of it. This does not, however, preclude further search activity from taking place at some future time. In general, the level of search activity among the women in the study was not extensive. However, one must be cognizant of the fact that recalling how often they had searched for information was difficult to do. The problems that women encountered during the search process may have also curtailed the level of search activity. For example, the majority of women in the study identified lack of information on menopause as their main concern.

Problems and Positive Experiences Encountered

The greatest problem women in this study encountered in searching for information was the lack of information or unavailability of information. This is a common problem particularly within the traditional health care system and one that was encountered in the studies conducted by Messerli et al (1980), Shapiro et al (1983) and Webb (1986). The quality of information available on the menopause was also questioned. This lack of good quality information may, in part, derive from the fact that many controversies are present in the literature e.g. risks and benefits of HRT. Another example illustrating this fact comes from one woman who felt there was a tendency to deny the biological element of menopause in the psychology literature. Women also wanted information they could relate to themselves. If information is written by a male from a male's perspective, it

may be more difficult for women who are seeking information to relate it to their menopausal experiences. This fact may also contribute to the women's perception that the information available was inadequate.

Women from the MIW, in particular, were dissatisfied with the traditional health care system as evidenced by their interest in the WHC and the MIW. Most of these women had had experiences where physicians had given them no information or information that was not congruent with their personal beliefs and values. The potential for thwarting further information search behaviors exists although about half of the women carried on with their search when they found information that was not useful. In this instance, the anticipated benefits e.g. reduction of anxiety and increased sense of control, seem to have outweighed the personal costs, e.g. frustration, time expenditure (Lenz, 1984).

The positive aspect of searching for information had been attendance at the MIW. Those who found the workshop positive appreciated the sharing among women, the new information they obtained and the misinformation that was corrected. The workshop format seemed to facilitate informal sharing of information amongst the participants. This is consistent with the beliefs of Webster and Lipetz (1986) who support the use of small groups in order to acknowledge and value the individual's past and current experiences. This sharing amongst women is characteristic of women's behavior (Cobb, 1988; Lenz, 1984) and affirms the use of personal sources of information for women in the climacteric.

LaRocca and Polit (1980) and Napholz (1985) found in their studies that women tended to talk freely with other women, family and friends. Kaufert (1980) also found that approximately two-thirds of the women in her study found it easy to discuss menopause with their physicians, husbands or friends.

Evaluation of Acquired Information

The overwhelming factor in determining the usefulness of information was whether or not the information could be related to the women themselves or to their experiences. This finding could be explained by the women's need to determine the normality of what they were experiencing. Of importance also was the need for women to find solutions to their problems or answers to their questions e.g. should estrogen be used, should surgery be performed. Lenz (1984) discusses the criteria used in evaluating information: comparison between information needed and obtained and/or a cost-benefit analysis. The relatedness of the information could perhaps be reflective of a cost-benefit analysis. For example, information was of benefit if it assisted them to determine that they and their menopausal experiences were normal or if it helped them in their decision-making.

Other less important factors which the women considered in evaluating information were the scientific properties of the information, the currency of the information, whether or not more than one point of view was expressed and the congruence with previously acquired knowledge or information.

Factors that Continue or Terminate the Search

Finding helpful information served as a cue for the majority of women in this study to stop their search either permanently or temporarily. For others, finding helpful information served as a cue to continued searching because of heightened interest and curiosity regarding menopause; for some, finding information that was not helpful was a cue to continue the search. Lenz (1984) discusses the concept of "high involvement" as individuals search for information. In this instance, menopause is seen as a constant stimulus. Some women viewed menopause as a constant stimulus because they wanted to know about new developments in research related to nutrition and Calcium supplements and also because they wanted to discuss menopause with their daughters. This may help to explain why both useful and not useful information were cues to further search activities.

Cognitive and Behavioral Outcomes

Lenz (1984) discusses the total set of information which an individual possesses at the end of a search. The set includes "previously acquired information, information acquired as a result of active search, and information acquired passively during the search process" (p. 66). She discusses further the complexity of determining the extent to which increase in information is attributable to active search behavior. Cognitive outcomes resulting from the search may include changes in opinions, attitudes or beliefs. Behavioral outcomes tend to be evidenced in a conscious choice on the part of the individual.

When viewed as part of the decision-making process, behavioral outcomes are "best considered indirect results of the information search process, since several cognitive processes related to weighing and selecting alternatives intervene between the acquisition of information and the manifestation of behavior" (Lenz, 1984, p. 66).

The majority of behavioral changes that women made related to the areas of nutrition intake and exercise patterns. A second area where women were effecting "psychological" changes was in their intra-personal and inter-personal relationships. The majority of these changes that had been made were based on information that women had found outside of the MIW. This finding would tend to support the fact that women are responding to the health information written in the lay literature (Cobb, 1988; Neal, 1987; Reitz, 1977; Voda, 1984) and also support Lenz's statement that impersonal sources of information should not be discounted. Three women, however, were able to identify changes they had made relative to the information from the MIW, e.g. one woman began to take Calcium supplements; two women decided against HRT. Although the number of changes made were few, those that were made were of importance.

While women who attended the MIW did not make many behavioral changes based on the information received at the workshop, they did find the workshop to be a positive experience. This could best be explained by the fact that most changes were effected in the cognitive domain. This fact is supported by data

identifying the reasons why women found the MIW positive, namely the sharing among women, the new information received and the misinformation that was corrected. Furthermore, the MIW may have helped to validate information that had been received prior to the workshop.

The women from the Alumnae who had searched for information made changes in their lifestyle based on information they had obtained. One woman regretted her decision not to take estrogen following her hysterectomy and oophorectomy. Her decision had been based on information from the professional literature. It appears that the controversy in the literature over the risks and benefits of HRT (Barrett-Connor, 1987; Gambrell, 1986) may have had a negative influence on this woman's decision-making.

Analysis of Lenz's Model

The information search process model described by Lenz (1984) provided a framework for the study that assisted in the development of research questions, data collection and analysis of the data. By using a model as a conceptual framework, however, a certain degree of restrictiveness was placed upon data collection in order to answer questions related to the steps of the model. Maintaining a focus on the steps of the information search process may have excluded other pertinent data from being collected. For example, better insight into the attitudes of health care workers may have been achieved if more indirect and less specific questions had been asked. Developing research questions that accurately reflected the steps of the model was

difficult for two reasons. First, some steps of the model e.g. information acquisition and codification, were very complex from a cognitive perspective, creating problems in formulating questions that would elicit the required data. Secondly, some steps of the model were similar to one another thereby creating problems in terms of differentiating between the steps e.g. information acquisition-codification and the evaluation phase. The women in the study also had to be articulate in order to describe the steps of the model.

Perhaps the most clearly identified step of the information search process was the stimulus to engage in information seeking. Women were definite as to the reason(s) for initiating the search process. They were also definite about the kinds of information they wanted regarding menopause, this being the goal setting step. Data collected on the women's decision to seek information actively was difficult to differentiate as this step was similar to the stimulus. For example, not having the required information was often the reason for women deciding to search actively. However, this was also viewed as a stimulus for initiating the search. Describing the extent of their search was difficult for most women as they could not always recall the number of search activities. Women were, however, able to identify the method of search as well as those personal or impersonal sources of information that were helpful or not helpful. The researcher was unable to collect pertinent data on information acquisition and codification as this was interwoven

with the evaluation phase and could not be differentiated. Women were able to identify how they evaluated information and how this evaluation affected further search behaviors. Cognitive and behavioral outcomes of the search were identified by the women. However, they were not always able to identify if these changes had been effected by previously acquired information, or by information actively or passively acquired during the search.

In summary, the majority of steps in the information search process of climacteric women could be described. However, data pertaining to two steps, decision-making related to actively seeking information and information acquisition and codification, were not fully described because of difficulty in delineating them. The model was able to explain the data adequately in relation to the stimulus for the search, the search behaviors, evaluation and outcome. Lenz (1984) hypothesized that the steps of the process occurred sequentially in a linear fashion with variation along several dimensions for most steps. The steps relating to decision making were perceived as being unidimensional. The data collected suggests, however, that the model is non-linear in character and very much a process. The importance of the attitudes of the personal sources of information was not addressed by the model but is an area which seems to have had great impact on the information search process. The utility of the model appears to be in relation to emphasizing to health care professionals that consumers of health care are seeking information and are engaging in a search process to

locate the required information. Furthermore, consumers of health care are making decisions based on the information they acquire. The difficulties with the model appear to be in operationalizing it as it tends to be linear when reality presents as being non-linear. In future studies, a different approach to describe the information search process would be worthwhile e.g. grounded theory. By using this type of approach, categories would not be predetermined but would evolve from the data.

Attitudes of Health Care Providers

As noted earlier, physicians were not perceived by the women in this study to be good sources of information even though the majority of women had consulted them. More importantly, the women expressed concerns that could best be described as relating to the attitude of the physician.

As sources of information, physicians were found to be inadequate in that women were often "rushed" in the physician's office. Women were sometimes told there was little information available on menopause or they were given inaccurate information. Some physicians were not seen as listening or understanding. Women were not always given clear explanations why certain procedures/treatments/therapies needed to be performed or initiated.

The information given by physicians, or the lack of adequate information, seemed to convey an attitude of not caring or understanding to the women searching for information. Women who

required hysterectomy and oophorectomy or had had this done in the past commented that physicians were very "nonchalant" about their bodies, that losing one's ovaries was not a problem if one was over 45 years of age. The women seemed to feel physicians did not care or understand what surgery or their health problems meant to them as women. As one woman commented, she felt that if men had dysmenorrhea they would not tell her it was "in your head." Another woman doubted the information her gynecologist gave her about hot flashes because he had never experienced them. In analyzing the data, it seemed that women encountered more difficulties with gynecologists than with family physicians. Perhaps this is because gynecologists may be more biomedically oriented than family physicians who tend to be more psychosocially oriented. This is consistent with the data of Lock (1982) who found these two different approaches used by gynecologists and family physicians.

Nurses were not approached for information by any of the women in the study. This is a finding that is rather surprising given that nurses comprise the largest group of providers in the health care system. However, this probably reflects some of the dissatisfaction that women feel toward the traditional health care system. Women who were hospitalized did not find nurses to be empathetic or understanding. This finding could perhaps be explained by a number of factors. One factor may be that nursing has been slow in addressing the whole issue of feminism (Baumgart, cited in Allen, 1985; Chinn & Wheeler, 1985). By

becoming more sensitive to feminist patterns of thinking, nurses may be more inclined to value the unique experiences of the individual woman and to empathize with those experiences. Another factor may be that women choose to use other women who are experiencing a similar problem/situation as sources of information rather than a nurse. Kaufert (1980), LaRocca and Polit (1980) and Napholz (1985) did find that women used friends as sources of information or for discussion of menopause. This need to talk with other women who were experiencing menopausal changes was an important stimulus for women to attend the MIW. Nurses, particularly of another age group or sex, may not be approached for information because they are seen as not possessing experiential information. Another factor which may pertain is the knowledge level of the nurse regarding menopause. If health care professionals are not knowledgeable or are not perceived as being knowledgeable, then individuals seeking information may not consult them. Another factor of considerable importance is the workload of the nurse. Nurses may find it difficult to be empathetic and understanding if functioning under great physical and emotional work demands. Perhaps the most significant factor is that the health care system is a powerful force in the socialization of health care professionals. The system often tends to value efficiency and productivity over the more "human" values of individuality, sensitivity and empathy. Nurses are in constant exposure to this kind of milieu and may tend to take on the values of the health care system.

The attitude of health care providers appears to have considerable impact on the information search process as it applies to climacteric women. If attitudes toward women and their experiences are not viewed by health care providers in a positive manner, women tend to seek information elsewhere. Or if information on menopause given by health care providers is not of satisfactory quality or is not available, women tend to reject it. They may search elsewhere or terminate the search.

Attitude toward Menopause

The mean of the MAS scores of the women who attended the MIW was lower than the mean for the women from the Alumnae who had looked for information and the Alumnae women who had not looked for information. The comments made by the women with regard to their feelings about the menopausal changes they were experiencing were consistent with the MAS scores. The women from the MIW expressed mainly "negative" feelings about their menopausal changes while women from the Alumnae tended to feel "positively" about the changes. Bowles (1986), in validating the MAS, tabulated a slightly lower mean score than the MIW group's mean score. She also found that age accounted for the greatest portion of variance in the final score. She identified that younger, pre-menopausal women, particularly 35 years of age and younger, expressed more negative feelings about menopause than those who were menopausal or post-menopausal. She did find, however, that there were no significant differences in scores in the 46 to 55 age category, the 56 to 65 and the over 65 age

categories. The mean score of the MAS in Bowles (1986) sample may have been lower than the MIW groups' mean because the majority of Bowles (1986) sample was below 45 years of age and pre-menopausal. The sample size in Bowles' study was also much larger (n=419).

Age may account for some variation in the MAS Scores of the MIW and Alumnae group. The mean age of women from the MIW was 47 years and from the Alumnae, 51 years, a difference of 4 years. The greater amount of variation, however, probably can be attributed to menopausal status. The majority of women from the MIW said they were beginning or in the middle of menopause. The majority of women from the Alumnae said they were in the middle or all through with menopause. The MIW women were peri-menopausal; the Alumnae women were post-menopausal. Women who are nearing the completion of menopause may have a more positive attitude toward it than those who are just beginning. No woman can predict what menopause will be like for her so as she progresses through the climacteric fear of the unknown may become lessened and may possibly make her attitude toward menopause more positive. Menopausal changes for the Alumnae group were also becoming less intense, possibly contributing to a greater sense of well-being.

The data indicate that women in this study who are actively searching for information have a less "positive" attitude toward menopause than those who are not. While age and menopausal status play a part in explaining this variation, the severity of

the menopausal changes themselves may play a role. When women from the Alumnae who had not looked for information were asked why they had not, the majority said it was because menopause was not posing any problems for them. Conversely, women who were looking for information had experienced menopausal changes which they needed to verify as "normal" and/or changes which were posing problems for them. As well, they had experienced a lack of or unavailability of information on menopause which they felt they needed. While women in this study who were seeking information about menopause had problems and concerns related to menopause, their greatest problem/concern/worry was not menopause. Only two women of all the women identified menopause and related factors as their greatest problem/concern/worry; all others related to general health, marriage and family life, career and finances. This is consistent with Cooke's (1985) findings that menopause can no longer be considered the exclusive reason for psychological distress in mid-life women as it has been in the past. This data is also consistent with the findings of Frey (1982), Leiblum and Swartzman (1986), and Lennon (1982).

Stressful life events as a contextual variable could, however, impact on women so as to intensify in a negative way their menopausal experiences and affect their attitude toward menopause. Women from the MIW were experiencing more stressful life events than women from the Alumnae. Women from the Alumnae tended to be experiencing normal developmental concerns characteristic of mid-life. For example, some were beginning to

think about or experience retirement; others were concerned for aging parents. The MIW group, on the other hand, was experiencing problems that were not of a developmental nature. Marriage breakdown was a problem for some while financial matters were a problem to others. Fear of cancer was stressful for some as was fear of surgery. Worry regarding their own health and health care was also a problem. This finding of more life stress among women attending menopause clinics is supported by Ballinger (1985) who concluded from her study that women presenting at menopause clinics did suffer significantly more from life stress than women who did not. Given our understanding of the general stress response, one can appreciate the physiological and psychological behaviors that accompany a stressful life event e.g. women regularly identified the role stress played in precipitating a hot flash.

As noted, women from the Alumnae, those seeking information and those not, were positive in attitude toward menopause. They felt that this particular developmental phase was a good time of life and they were feeling healthy. This is consistent with Griffith's (1983) study in which she found that older women had fewer stressors and those that they had were perceived as less important than those of younger women. Kaufert (1983) found that the generally prevailing attitude toward menopause among women she studied was one of relief that they had had their last menses. Given that the majority of Alumnae women were post-

menopausal, this may have accounted for some of their feelings of well-being and their positive attitude toward menopause.

Sample Characteristics

Women from both groups were not suffering from "empty nests" as all women save one had at least one child living at home. These data are supported by Carroll (1983) and also by Kaufert (1983) who found in her study that over half of the women aged 40-59 had children at home. In this study, the children who lived at home tended to be young adults in their early twenties. Having young adults living with parents can bring problems of their own although this was not identified by the women as a particular problem or concern.

There is considerable support in the literature for the positive effects on health of having multiple roles (Nathanson, 1980; Verbrugge, 1986). Women from both groups were involved in many role behaviors as parents, wives, employees and community volunteers. This variable, however, did not seem to affect the women's search behaviors as there were as many role behaviors in the information seeking group as in the non-information seeking group.

With respect to the marital role, however, there were a few women in the MIW group who were divorced and separated and one who was experiencing marriage breakdown. These events can be stressful and as McKinlay et al (1987b) note, may contribute to depression in women. One woman, in particular, had come to the MIW to determine if her depression was due to her recent

separation or to her menopause. Uphold and Susman (1985) found that marital adjustment was one of the best predictors of decreased symptomatology in the climacteric. This finding suggests that marital strife may contribute to increased symptomatology in the climacteric.

Regarding employment, the majority of MIW women were employed in non-professional positions while the Alumnae women were employed in professional positions. Hibbard and Pope (1985) note that women in higher status jobs have better health indicators than those in lower status jobs. This finding is supported by McKinlay et al (1987b) who identify women in clerical jobs with less than 12 years of education as being more depressed than women with a better education or career-oriented employment. Job dissatisfaction could perhaps play some part in contributing to the general stress levels of the MIW women which in turn may have some effect on their experience of the menopause. However, this conclusion could not be made with any certainty given that data regarding levels of job satisfaction and dissatisfaction were not collected.

All women in both groups, with the exception of one from the MIW, had a high school certificate. The majority of women seeking information were educated beyond the high school level. Education, which is a reflection of socio-economic status, has a positive effect on search behaviors. Lenz (1984) found that persons with higher socio-economic status engage in more extensive search behaviors because they have better cognitive

skills, greater interest in health matters, similar beliefs as health professionals, fewer financial constraints, and greater access to social networks that can serve as information sources. This variable, however, did not seem to exert any particular effect on the information search process in that women who were seeking information and women who were not seeking information were well educated. In order to understand the effect of education and socio-economic status on the information search process, data would need to be collected from women in lower socio-economic groups. To date, the majority, if not all, of the studies related to menopause have utilized middle class women as subjects (Bowles, 1986; LaRocca and Polit, 1980; Uphold and Susman, 1985).

Medicalization of the menopause in terms of taking HRT did not occur to a high degree in either group of women in the study. This is consistent with Kaufert and Gilbert's (1986) findings in which menopause was not highly medicalized and in which physicians were often not involved at all. Medicalization implies that a woman's menopause is closely monitored by a physician and involves the use of HRT (Mac Pherson, 1981, 1985). Women in the study were, however, very quick to use the word "symptom" when describing their menopausal changes. In addition, the physicians of those women seeking information were almost always consulted initially regarding menopausal changes. This is in contrast to Kaufert and Gilbert's (1986) findings and may be explained by the fact that they were sampling from the general

population of women in Manitoba, not two select groups of women, the MIW and the Alumnae.

A great deal of medicalization was seen in the amount of surgery that had been performed on both groups of women throughout their reproductive and post-reproductive years. For example, one-third of both groups of women had had hysterectomies and/or oophorectomies. This high rate of surgery is reflected in the literature (Kasper, 1985). Kasper notes that many authors believe that one-half of all American women will have a hysterectomy in the second half of their life. She also believes that this high rate of hysterectomy reflects the power and control that physicians have in the lives of women.

Conclusions

The information search process model as described by Lenz (1984) provided a framework for the study and, in turn, the data that were collected helped to validate some aspects of the model. Menopausal changes were a stimulus to seek information if those changes were seen as problematic or if the woman needed to validate that the changes were normal. Women in this study who were seeking information seemed to be experiencing greater and different life stressors than those who were not seeking information. Those women who were searching for information also had less positive MAS Scores than those who were not and expressed more negative feelings about menopause when interviewed than those who were not looking for information. Age is an

important factor in attitude toward menopause (Bowles, 1986) with younger women having more negative feelings about menopause than older women. The women looking for information were peri-menopausal and younger while those not looking for information were older and post-menopausal. In conclusion, it would seem that a combination of age, menopausal status, life stress and severity of menopausal problems stimulate a woman to seek information.

Women from the MIW seemed to experience menopausal changes at an earlier age than women from the Alumnae. Their menopausal changes were more intense than those of the Alumnae group and on interview, they talked at much greater length about their experiences than the Alumnae women. Women from the MIW, however, are not representative of menopausal women as the majority of women in the general population tend to experience menopause with relatively few problems. This fact serves to emphasize the uniqueness of the menopausal experience for women and the importance of caring for each woman on an individual basis.

Women in the study were definite about the kinds of information that they wanted about menopause. They were able to set goals, a step in the search process, which were related to the specific stimuli. They were all well educated, middle class women who could, in most instances, easily articulate their informational needs. Women from lower socio-economic groups were not represented in the study. However, knowing what the informational needs of women from lower socio-economic groups

are, how they articulate their informational needs, and what menopausal changes they experience in light of their particular environment would be useful for health care professionals to know because the majority of the research conducted related to menopause has utilized white, middle class women as subjects.

The lack or unavailability of information on menopause identified by the women in this study was a problem for them and may be reflective of the control the medical profession has exerted over information pertaining to health matters of women. This situation appears to be changing, however, as the numbers of mid-life women increase and more women band together to share information and write about menopause e.g. the Boston Women's Health Collective and Janine O'Leary Cobb. The popularity of the MIW would attest to this increased sharing of experiences and information on the part of climacteric women.

In general, attitudes of health care providers were a source of concern to women and may have had a negative impact on the information search process. Nurses were not perceived as sources of information on menopause and were not viewed as being empathetic or understanding of women who were hospitalized. While physicians were contacted in relation to menopausal changes, they tended not to be seen as good sources of information by the women in the study. This response on the part of physicians seemed to provide further stimulus for the information search to continue. One wonders what subsequent search behaviors would have taken place if women had been able to

obtain the information they wanted from the physician. For the women in this study, a great deal of medicalization of the menopause had occurred as evidenced by the high rates of hysterectomy and oophorectomy and the frequency of consultation with physicians.

Regarding menopausal status, the data emphasized the importance of basing status on more than one variable e.g. last menstrual period. With the MIW group, the majority of the women had menstruated in the last three months. If this definition alone had been used to determine menopausal status, then these women would have been considered pre-menopausal rather than peri-menopausal. For this reason, data collection must include information about regularity of menstrual pattern as well as information about other menopausal changes pertinent to the culture being studied e.g. hot flashes. In this study, the perceptions women had regarding their menopausal status tended to agree with menstrual pattern information and other menopausal changes.

This study has served to emphasize the fact that people are searching for health information, in this case, information about menopause. Health care professionals must be cognizant of this fact and become involved in the information search process. Actively searching for information on the menopause and climacteric can be an effective strategy for women to become informed and be a part of the decision-making process. If the information search process is to be effective, however, women

must be able to locate the information they require through personal or impersonal sources. Health care professionals such as physicians and nurses need to become better sources of information for women so as to facilitate the information search process.

Implications for Nursing

Nursing Education

An important implication for nursing education is to question the way in which philosophies of nursing and nursing content address male/female perspectives. As Webster and Lipetz (1986) note, women's experiences need to be recognized as diverse and distinct from those of men. This recognition needs to take place at both a philosophical and practical level in nursing education. If nurses are to understand women, they must be informed about the physiological and psychosocial variables that pertain to women throughout the life cycle. Menopause and the climacteric as a normal, developmental experience should be identified in nursing curricula, specifically in courses related to human growth and development, if nursing students are to gain some understanding of women's health in mid-life. Of importance also is an understanding of issues relating to women's roles in contemporary society as women's health must be understood in relation to the social environment. Furthermore, nursing students require an understanding of the health care system

particularly in relation to how the system cares for women e.g. medicalization of normal life events.

As well as learning the nursing process, nursing students should be aware of the information search process, its benefits and the factors affecting it. Students should also be aware of the fact that clients may be actively seeking information about their health and wanting to be involved in making decisions about their health. Nursing students need to understand that they can and should be sources of information to clients and efforts should be directed toward helping clients perceive nurses as sources of information. Students also need to be aware that if clients are to make decisions based on health information they provide, then information must point out the advantages and disadvantages of a particular decision or behavior.

Many nursing education programs are addressing the concept of the client as an active participant in decision-making, the role of the nurse as facilitator of decision-making rather than decision-maker, and the unique biological and psychosocial aspects of being a woman or man in comtemporary society. However, a concerted and sustained effort is required to ensure that these concepts continue to be addressed and developed in nursing curricula.

Nursing Practice

The study of the information search process in climacteric women provides several implications for nursing practice as it relates to the health of mid-life women. First, this study

provides insight into the psychological and physiological aspects of the menopausal experience which can improve the quality of nursing care provided to climacteric women. If this is to happen, nurses must be knowledgeable regarding the climacteric and menopause, both natural and artificial, and the nursing care required. Nurses providing care to women in gynecological areas of acute care institutions where surgical intervention may produce a sudden, artificial menopause need to inform women about the surgery and its immediate and long-term effects. Continuing education must be made available to nurses so that they are able to provide care to menopausal women that is based on current and accurate knowledge. For those nurses specializing in women's health, the issue of medicalization of the menopause should be discussed as this is fundamental to a complete awareness of how the health care system, specifically the medical profession, cares for women. As well, nurses at this level must be aware of menopausal changes that can occur and be knowledgeable about the various methods of dealing with menopausal changes. More specifically, the nurse must be aware of the risks and benefits of HRT.

Secondly, in this study the kinds of information climacteric women want were identified. This provides the nursing profession with direction in terms of what their knowledge base needs to be to provide appropriate health information to climacteric women. Nurses also need to be aware of the many impersonal and personal sources of information that women use and with what effect.

Nurses must evaluate these sources of information and improve strategies whereby optimum use is made of all sources. The workshop format/strategy has proven to be an effective, personal source of information for women and should continue to be co-ordinated and supported by the nursing profession. In addition, the study identified that women use impersonal sources of information such as books, articles and pamphlets. Nurses can and should be capitalizing on this opportunity to reach women by writing books, articles and pamphlets especially for climacteric women. By writing about menopause and presenting workshops about menopause, nurses can help women to perceive them as valuable sources of information.

A third implication pertains to the fact that women from all socio-economic levels may require information about the climacteric. Assessing the information that women from lower socio-economic groups would want is difficult as their interaction with health care professionals is often episodic and crisis-oriented. In view of this, nurses should be encouraging the public education system to incorporate a more comprehensive study of the life cycle into schools, one that would include study of the climacteric as well as the menarche. In addition, community health nurses should be assessing the informational needs of climacteric women in all socio-economic levels and providing the required information in an appropriate format e.g. a workshop, informal discussion.

If nurses are to support the concept of active information searching on the part of individuals, they will need to be educated and re-educated to assume the role of facilitator of this process. Nurses can facilitate the process by being knowledgeable about the climacteric themselves and also by being knowledgeable about other sources of information for climacteric women. Through a better understanding of women's health issues, in general, and the climacteric, in particular, nurses would have increased understanding of and sensitivity to the special needs of women at this stage of life. This would assist in establishing a rapport and promoting the nurse's role as facilitator.

While nurses do not need to be feminists to provide sensitive care to women, an examination of the relationship between feminism and nursing might assist nurses to become more sensitive to women's health issues. Chinn and Wheeler (1985) define feminism as "a world view that values women and that confronts systematic injustices based on gender" (p. 74). While Kerr (1988) notes that some feel feminism is "against men and traditional institutions" (p. 60), she points out that feminism values both men and women. Feminism has been instrumental in facilitating the establishment and progress of the women's health movement. The traditional roles of men and women in society have been challenged and has paved the way for alternative health care for women. Feminism has helped women to realize that they have a right to health information and a right to be involved in

decision-making related to their health. Nurses need to understand what feminism is and what it is not. They need to understand the women's health movement and the needs of women as health care consumers.

Nursing Research

During the course of the study several questions and ideas were raised that could be pursued at a research level. An important follow-up study to this one would be a longitudinal study of the information search process in climacteric women. The present study looked at a relatively short period of time in a woman's life with no data pertaining to the information search process as a woman begins and progresses through her climacteric. The knowledge this type of study would yield could have some very positive outcomes in terms of the nursing care provided to climacteric women, for example, an awareness of the changing informational needs of women throughout the climacteric. Other recommendations for further research are as follows:

1. replication of the study using a larger sample size and a group of women other than nurses.

2. prospective study to determine predictively what stimuli (stimulus) prompts climacteric women to seek information.

3. evaluation studies of personal and impersonal information sources regarding menopause/climacteric as to their effectiveness as sources of information.

4. a description of the menopausal experience in

climacteric women of lower socio-economic groups and their needs for information.

5. determination of the relationship of internal locus of control and information seeking behaviors of climacteric women.

6. determination of the knowledge levels of physicians and nurses regarding the climacteric and their attitude toward menopause/climacteric.

7. determination of the extent to which nursing knowledge and attitude toward the climacteric are related to feminism.

8. a description of the information search process as it applies to nurses and their nursing role.

Summary

The purpose of this study was to describe the information search process in two groups of climacteric women, those women who had attended the MIW and those women who were members of a Nurses' Alumnae. Eleven women from the MIW and seven women from the Alumnae volunteered to participate in a semi-structured interview and short questionnaire.

The findings of the study revealed that some climacteric women are searching actively for information about menopause. Stimuli, both internal and external, physiological and psychological, are prompting women to seek information to determine what is normal and if they are normal, to help them make decisions and to be well informed in a general sense. Women seeking information were able to identify the information that

they wanted or required. Both personal and impersonal sources were used in gathering information. The MIW, a personal source of information, was perceived very positively by the women seeking information there. Information that was inadequate or unavailable was seen to be the greatest problem for women when seeking information. The single most important factor in evaluating the usefulness of information was whether or not the women could relate it to themselves and their experiences. Some of the women in the study did effect some behavioral changes based on information they had found during their search. The women searching for information were younger, peri-menopausal, had a more negative attitude toward menopause, had greater life stress, and more severe menopausal problems than those women who were not searching for information. Those women who were not seeking information said menopause was normal for them, was not posing any problems, and they felt they had access to the necessary information.

Women who were searching for information encountered problems in obtaining the information they required from physicians. Physicians were sometimes seen as not caring or understanding when interacting with women. Similarly, women who were hospitalized for hysterectomy and oophorectomy did not find nurses to be empathetic or understanding. Nurses were not utilized as sources of information by any of the women seeking information. A high rate of hysterectomy and oophorectomy was noted for all women in the study, lending credence to the

perspective that certain phases of the women's life cycle were highly medicalized.

The information search process model described by Lenz (1984) provided a framework for the study that assisted the researcher in the development of the research questions, the data collection and the analysis of the data. The model was able to explain the data adequately in relation to the stimulus for the search, the search behaviors, evaluation and outcome. The attitudes of health care providers were not addressed by the model although this area tended to have great impact on the information search process.

Several implications for nursing were identified from this study. Nurses caring for climacteric women must be knowledgeable regarding the physiological and psychological aspects of both artificial and natural menopause. In addition, they must be informed regarding the management of menopausal problems, particularly the risks and benefits of HRT. Nurses also need to be aware of the kinds of information women want regarding menopause and project an image whereby women perceive nurses as sources of information. Furthermore, nursing students should be educated in such a way that menopause is viewed as a normal, developmental experience in the life cycle.

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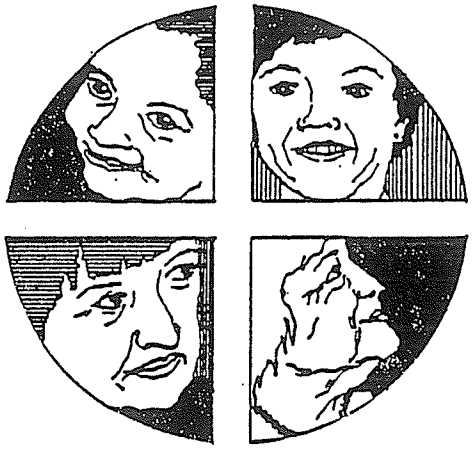
Appendix A

MENOPAUSE INFORMATION WORKSHOP

WOMEN'S HEALTH CLINIC
MENOPAUSE
INFORMATION WORKSHOP



SATURDAY MAY 2, 1987

9 A.M. TO 4 P.M.

WOMEN'S HEALTH CLINIC
304-414 GRAHAM AVE.
WINNIPEG
R3C OL8

ISSUES TO BE ADDRESSED:

PHYSIOLOGY AND SYMPTOMS
HOT FLASHES - NIGHT SWEATS - EMOTIONAL ASPECTS
OSTEOPOROSIS
SELF-HELP AND MEDICAL TREATMENTS
NUTRITION AND EXERCISE
HORMONE REPLACEMENT THERAPY
AND MORE...

FOR FURTHER INFORMATION, CALL
W.H.C. 947-1517

* ENROLLMENT IS LIMITED TO 25 *

over

WOMEN'S HEALTH CLINIC

MENOPAUSE INFORMATION WORKSHOP

Saturday, May 2, 1987

8:30 - 9:00	COFFEE AND REGISTRATION
9:00 - 9:15	INTRODUCTION AND PROGRAM OUTLINE
9:15 - 10:00	PHYSIOLOGY AND SYMPTOMS OF MENOPAUSE: INCLUDING: Hot Flashes Night Sweats Vaginal Atrophy Emotional Aspects Surgical and Natural Menopause
10:00 - 10:30	SMALL GROUP DISCUSSIONS
10:30 - 10:45	COFFEE
10:45 - 11:15	GROUP DISCUSSION FEEDBACK
11:15 - 11:45	SOCIAL AND INTERPERSONAL ISSUES OF AGING
11:45 - 12:00	FILM
12:00 - 1:00	LUNCH
1:00 - 1:15	OSTEOPOROSIS
1:15 - 2:00	TREATMENTS: Including: Hormone Replacement Therapy Surgery Self-Help Methods Nutrition and Exercise
2:00 - 2:45	SMALL GROUP DISCUSSIONS
2:45 - 3:00	TEA
3:00 - 3:30	GROUP DISCUSSION FEEDBACK
3:30 - 4:00	SUMMATION AND EVALUATION

To register, complete and send the following section to:

MENOPAUSE INFORMATION WORKSHOP
Women's Health Clinic
304 - 414 Graham Avenue
Winnipeg, Manitoba R3C 0L8

NAME: _____

ADDRESS: _____ Postal Code: _____

PHONE: Residence: _____

Business or Messages: _____

Please list below any special concerns that you would like to have discussed:

_____

_____

I would like to have lunch provided.
Enclosed is my $5.00 ☐

I will bring my own bag lunch. ☐

Appendix B

MENOPAUSE ATTITUDE SCALE

MENOPAUSE SCALE INSTRUCTIONS

The purpose of this scale is to find out what different people think about the experience of menopause. This is done by having them indicate their degree of feelings using a set of adjective scales that describe things a woman may experience during menopause.

Please indicate how you feel about the experience of menopause in terms of what each set of adjectives means to you.

FOR EXAMPLE:

If you think that feelings a woman has during menopause are extremely related to one end of the scale, you might place your check mark as follows:

DURING MENOPAUSE A WOMAN FEELS,

Good ___X___:_____:_____:_____:_____:_____:_____ Bad

If you think that feelings a woman has during menopause are quite related to one end of the scale, you might place your check mark as follows:

DURING MENOPAUSE A WOMAN FEELS,

Good _____:_____:_____:_____:_____:___X___:_____ Bad

If you think that feelings a woman has during menopause are slightly related to one end of the scale, you might place your check mark as follows:

DURING MENOPAUSE A WOMAN FEELS,

Good _____:_____:___X___:_____:_____:_____:_____ Bad

If you think that feelings a woman has during menopause are related to both ends equally, place your check mark in the middle space.

DURING MENOPAUSE,A WOMAN FEELS,

Good _____:_____:_____:___X___:_____:_____:_____ Bad

Please complete all the scales.

DURING MENOPAUSE A WOMAN FEELS

Important	_____:_____:_____:_____:_____:_____:_____	Unimportant
Passive	_____:_____:_____:_____:_____:_____:_____	Active
Clean	_____:_____:_____:_____:_____:_____:_____	Dirty
Fresh	_____:_____:_____:_____:_____:_____:_____	Stale
Dumb	_____:_____:_____:_____:_____:_____:_____	Intelligent
Sharp	_____:_____:_____:_____:_____:_____:_____	Dull
Unsure	_____:_____:_____:_____:_____:_____:_____	Confident
Worthless	_____:_____:_____:_____:_____:_____:_____	Valuable
High	_____:_____:_____:_____:_____:_____:_____	Low
Strong	_____:_____:_____:_____:_____:_____:_____	Weak
Unattractive	_____:_____:_____:_____:_____:_____:_____	Attractive
Pessimistic	_____:_____:_____:_____:_____:_____:_____	Optimistic
Full	_____:_____:_____:_____:_____:_____:_____	Empty
Pleasant	_____:_____:_____:_____:_____:_____:_____	Unpleasant
Ugly	_____:_____:_____:_____:_____:_____:_____	Beautiful
Needed	_____:_____:_____:_____:_____:_____:_____	Unneeded
Useful	_____:_____:_____:_____:_____:_____:_____	Useless
Interesting	_____:_____:_____:_____:_____:_____:_____	Boring
Unsuccessful	_____:_____:_____:_____:_____:_____:_____	Successful
Alive	_____:_____:_____:_____:_____:_____:_____	Dead

Appendix C

INTERVIEW FORMAT AND QUESTIONNAIRE

Semi-Structured Interview Format

FORM I - for women who have attended the MIW.

FORM II - for female nurse Alumnae Members.

FORM I

Thank you for agreeing to meet with me to discuss your menopausal experience and the information search process.

1. Would you please describe for me the menopausal changes, if any, that you are presently experiencing or have experienced. How do you feel about these changes?

2. Tell me about the kind of health information that would be useful to you as a woman at this time of your life.

3. Describe for me what happened that made you realize you needed information about the menopause. (More specifically, what prompted the woman to attend the MIW).

4. In addition to attending the MIW, where-else have you looked for information regarding the menopause? What information have you been able to find? How often have you searched for information? Have you contacted any particular people for information?

5. Have you encountered any problems/difficulties in looking for information? What positive experiences have you had in looking for information? How do you know when the information is useful or helpful? Not useful or helpful? How does this affect further information seeking on your part? Are there any other factors that have prompted you to continue searching or to stop searching?

6. Tell me about the changes (if any) you have made in your life/lifestyle as a result of the health information you acquired.

7. Describe to me your greatest problem/concern/worry facing you at this time in your life. In your opinion, what would help to alleviate this problem/concern/worry? Please describe it if you can.

8. If the following information has not come out during the interview, I would then ask:

   a) Are you under a physician's care at this time? If so, would you please tell me why?

   b) Are you on any medications at this time? Please tell me about them.

   c) Have you had any surgery on your uterus(womb) or ovaries? Would you please describe the surgery(surgeries)?

9. Do you have any other comments that you would like to make at this time?

Thank you.

Form II

Thank you for agreeing to meet with me to discuss your menopausal experience and the information search process.

1. Would you please describe for me the menopausal changes, if any, that you are presently experiencing or have experienced? How do you feel about these changes?

2. Tell me about the kind of information that would be useful to you as a woman at this time of your life.

3. Have you felt a need to look for any information regarding the menopause? If so, would you describe for me what made you realize you needed information about the menopause.

If the answer to question #3 was "yes", then questions #4 through #6 would be asked:

4. Where have you looked for information regarding the menpause? What information have you been able to find? How often have you searched for information? Have you contacted any particular people for information?

5. Have you encountered any problems/difficulties in looking for information? What positive experiences have you had in looking for information? How do you know when the information is useful or helpful? Not useful or helpful? How does this affect further information seeking on your part? Are there any other factors that have prompted you to continue searching or to stop searching?

6. Tell me about the changes (if any) you have made in your life/ lifestyle as a result of the health information you acquired.

If the answer to question #3 was "no", then this would be asked: Would you describe for me why you have felt no need to search for information regarding menopause.

7. Describe to me your greatest problem/concern/worry facing you at this time in your life. In your opinion, what would help to alleviate this problem/concern/worry? Please describe it if you can.

8. If the following information has not come out during the interview, I would then ask:

   a) Are you under a physician's care at this time? If so, would you please tell me why?

   b) Are you on any medications at this time? Please tell me about them.

   c) Have you had any surgery on your uterus (womb) or ovaries? Would you please describe the surgery(surgeries)?

9. Do you have any other comments that you would like to make at this time?

Thank you.

Note: During the interview, the researcher will attempt to use indirect questionning as much as possible in order to encourage the respondents to elaborate.

Personal Information

In order to have a better understanding of you, I would ask that you complete the following questions.

1. What is your birthdate? _____

2. What is your marital status? (Check one only.)

   ( ) Single (never married)
   ( ) Married or common-law
   ( ) Separated
   ( ) Divorced
   ( ) Widowed

3. Do you have children? ( ) Yes ( ) No

   If "yes", how many do you have? _____
   (Please state number.)

   How many children live at home? _____
   (Please state number.)

4. Are you employed? (Check one.) ( ) Yes ( ) No

   Are you employed on a full-time (F/T) or part-time (P/T) basis? (Check one.) ( ) F/T ( ) P/T

   What kind of work are you presently doing? (Please describe.)

   _____

   _____

5. How far did you go in school? (Check one only.)

   ( ) less than Grade 9.
   ( ) partial completion of either Grade 10, 11 or 12.
   ( ) complete high school certificate.
   ( ) diploma or certificate from a post-secondary institution.
   ( ) university bachelor's degree.
   ( ) advanced university degree.

6. Are you involved in community activities? e.g. church or school groups, charitable organizations, etc.

( ) Yes ( ) No

Please describe your activities if you answered "yes".

_____

_____

_____

7. Have you recently experienced any events in your life that have been upsetting or stressful to you?

( ) Yes ( ) No

If you answered "yes", please describe the event(s).

_____

_____

_____

*8. When was your last menstrual period? (Check one only.)

( ) less than three months ago.
( ) more than three but less than twelve months ago.
( ) more than one but less than two years ago.
( ) more than two but less than five years ago.
( ) more than five years ago.
( ) don't remember.

*9. Do you think that you yourself are....(Check one only.)

( ) all through with the menopause.
( ) in the middle of the menopause.
( ) just beginning the menopause.
( ) without any sign of the menopause.

* Used with permission of Dr. P. Kaufert.

Thank you for answering these questions.

Appendix D

INVITATION TO PARTICIPATE

INVITATION TO PARTICIPATE

You are invited to participate in a study examining the information search process in women experiencing menopausal changes or anticipating the beginning of these changes. In studying the information search process, I will be looking at the kinds of information women at this stage require, how they go about getting this information, what stimulates them to look for information, and how they use the information once they have acquired it. I will also be asking some questions of a more personal nature e.g. are you married? employed? etc., as well as questions relating to attitude toward menopause. Obtaining your perspective will help nurses to be better equipped to meet the informational needs of menopausal women.

If you agree to participate in this study, it will involve an interview and short questionnaire which will take approximately 1-1½ hours of your time. There are no right or wrong answers to any of the questions and you do not have to answer all of the questions if you choose not to. The interview will take place at a time and place that is convenient to you. The interview will be tape recorded and notes will be taken to assist me in recalling your answers. Should you wish, the tape recorder will not be used.

The decision to participate is entirely yours. If you do not wish to participate, it will not affect your future involvement at the Women's Health Clinic. If you wish, you may withdraw from the study at any time. Everything you say will be treated confidentially and you will be identified by a number known only to the investigator. The results of the study will be based on group analysis so that no will know how you as an individual answered the questions.

Once the study is completed, a report will be written and if you would like a copy you may indicate so on the consent form. The study results may also be published in a journal article. In the report (and article), what you have said to me will be written so that you cannot be recognized. The written notes and tapes from the interviews will be kept in a locked box. Only myself and three professors at the University of Manitoba will have access to this locked box. One year after the study is completed, this information from the interviews will be destroyed.

Thank you for considering my request.

Carolyn Vogt
Researcher

Appendix E

CONSENT FORM

CONSENT

I, _____, agree to participate in a study of the information search process in menopausal women. I have received a written and verbal explanation of the study by the researcher, Carolyn Vogt, who is a graduate student in nursing at the University of Manitoba. Any questions I have had have been answered to my satisfaction.

I understand that I will be participating in an interview that *will, will not be tape recorded, and a short questionnaire. Approximately 1-1½ hours will be needed to complete the interview and questionnaire. Information collected during the interview and from the questionnaire will be held in confidence and will be kept in a locked box. Only the researcher, Carolyn Vogt and 3 university professors will have access to this information. One year following the completion of the study, this information will be destroyed.

I understand that my decision to participate is voluntary and that I have the option to withdraw at any time or refuse to answer any of the questions. I understand that my participation in this study will not affect my future involvement at the Women's Health Clinic (or the Nurses' Alumnae).

My signature indicates that I am informed and that I agree to participate as a volunteer respondent.

_____ _____

Date Signature of Respondent

_____

Signature of Researcher

* delete and initial the appropriate word(s).

Carolyn Vogt
Phone: 837-0373 (work)
633-5021 (home)

Please print your name and address if you wish to receive a copy of the results of this study.

Name: _____

Address: _____

_____

Appendix F

LETTER TO ALUMNAE MEMBERS

Winnipeg, Manitoba

Dear

This letter is to introduce to you Carolyn Vogt, a graduate student in nursing, who is doing a project on the information needs of women experiencing menopausal changes. This study will be a thesis that will fulfill certain requirements for a Masters degree in Nursing.

In doing this study, she will be looking at the kinds of information women in this age group need, how they go about getting the information, what causes them to look for information, and how they use the information. As well, she will be looking at certain characteristics of women that help to define a person's role in life e.g. whether they are married or not, whether they are employed or not, etc. The last thing she will be studying is the attitude that women have toward the menopause.

The reason the Executive is contacting you is that women in the 48-52 age range are required to discuss their informational needs in relation to menopause. Approximately 1-1½ hours of your time would be required to participate in the interview and answer a few written questions. Please refer to the enclosed sheet entitled, "Invitation to Participate" for more information.

If you are interested in participating, please return the attached form indicating your interest. Your name, address and telephone number will then be shared with Carolyn Vogt who will contact you by telephone or letter if unable to reach you by telephone. If you wish to contact her directly you may do so by phoning 633-5021 (home) or 837-0373 (work). If you choose not to participate in the study, this information will not be shared with her. You are under no obligation to the Executive to participate in the study unless you choose to.

Thank you for your consideration.

Sincerely

(Mrs) Melissa Milton
President
Nurses' Alumnae

cc: Dr. Janet Beaton, Advisor & Chair, Thesis Committee, University of Manitoba, School of Nursing.
Mrs. Carolyn Vogt, Graduate Student.

Appendix G

TELEPHONE CONTACT WITH ALUMNAE MEMBERS

Phone Contact with Women to Finalize Interview Date and Time

Hello,

My name is Carolyn Vogt. I am the graduate student in nursing who is doing the study on the information search process in menopausal women. Your Alumnae Executive has just forwarded your name, address and telephone number to me indicating your interest in being involved in the study.

If you are still interested in participating we would need to meet at a mutually convenient time and place for approximately 1-1½ hours. At that time, we would talk for about 45-60 minutes. Following this there would be a short questionnaire for you to complete which would take approximately 15 minutes. If you would feel comfortable I would like to tape record our conversation. If this would bother you, I will not use the tape recorder.

(Specific arrangements would then be made to meet; a consent form would be signed at that time. If the respondent declined, I would thank her for her consideration.)