

CHAPTER 1

Orientation to the study

1.1 INTRODUCTION

Since the 1990s, women's health has received much attention as a speciality and discipline in the United States of America (USA). Many factors have contributed to this phenomenon. In the USA, women outlive men and are therefore more likely to experience the effects of chronic disease as they age. Women use the health services more than men, whether for those for whom they are caring or for themselves. The population of older adults is predominantly female and the majority of them are poor, have multiple health problems, and have outlived their support systems. While it is true that women in the USA for the most part enjoy a higher standard of health than the majority of women globally, they still face challenges as they age in transition from the reproductive years to the menopause (Condon 2004:502). Women's health includes their health and well-being across the lifespan. To this end, there has been a movement away from childbearing and matters linked to the reproductive years alone. This study develops and describes a model for the support of women during midlife transition based on their experiences of this stage of life.

1.2 BACKGROUND TO THE PROBLEM

Gender impacts on the lives of women in many ways but specifically in healthcare service and delivery. Women in the USA enjoy a social status that is unparalleled in other parts of the world (Legato, Padus & Slaughter 1997:190). Legislative reform has provided a gender-sensitive environment that is conducive to equity and equality for American women but in spite of this, healthcare remains an area where the specific needs and rights of women remain inequitable. Condon (2004:16)

suggests that women's healthcare has been more medicalized than the healthcare of men, that women "have been cast as inherently weak and sick because of their sex".

Gender difference in healthcare is not new. The Women's Health Movement (1960-1970) started because women challenged the then medical authority, particularly with regard to reproductive issues. Women at that time were not allowed access to medical information unless they were doctors and the medical profession was predominately male. Over time this challenge was expanded to include health matters across the lifespan and to this end, the Kennedy administration in 1961 established the Presidential Commission on the Status of Women whose report confirmed, "women were discriminated against not only overtly, but subtly" (Matteson 2001:22). The feminist movement of the 1960s is credited with highlighting the need to address the specific health needs of women. The feminist movement was criticized for perpetuating the paternalistic medical model and encouraging services geared to women but emanating from a male perspective (Condon 2004:17). Legato et al (1997:198) refer to this as the "tacit assumption that females are simply smaller versions of males". The medical model of healthcare delivery has largely ignored the fact that there are significant differences in the normal physiology of men and women. The Food and Drug Administration (FDA) only revised its policy of exclusion of all women of childbearing age from all drug trials in 1993. Previous to that women were excluded from all trials and so, to a large degree, women were given the decreased version of all pharmaceuticals, irrespective of the impact of biological differences in the pharmacokinetics. This impacted not only on the effects of drugs on disease process but also meant that women were excluded from research trials that addressed the progress and outcomes of disease and disease patterns, even those that specifically affected women (Matteson 2001:26).

Although women live longer than men in the USA, they have more non- fatal health problems that impact on the ways in which longevity is managed and enjoyed. There are differences between males and females in the occurrence of disease, survival of the onslaught of disease, the chronicity of disease and the way in which health is managed. The biological differences that exist between men and women are evidenced across the lifespan.

Men have less disease, but women live longer (Condon 2004:33). Current statistics reflect that women in the USA live five to seven years longer than men. There are differences that are known to occur in utero; 115 male babies are conceived to every 100 female babies, yet abortion of male foetuses occurs more commonly. Premature male neonates have a lower survival rate than female premature infants. Another factor thought to impact on longevity of women is what is termed the "genetic advantage". Women have XX-chromosomes and the X-chromosome is thought to contain the gene responsible for repairing damaged DNA (Condon 2004:11). Men have only one X-chromosome and this makes them more vulnerable to some cancers and other communicable diseases. Kimura (1999:52) found that women appear to have more competent immune systems that make them less susceptible to many communicable diseases.

Hormonal function is another biological difference that alters health status and impacts on longevity. Oestrogen is thought to provide cardio protection by decreasing cholesterol, specifically low density lipoprotein (LDL), a key player in cardiac health, on the one hand, but one that becomes a risk factor to be considered in relation to stroke events, on the other hand (Condon 2004:235). One in five women between the ages of 45 and 65 years is estimated to have heart disease. Cardiovascular disease (CVD) kills 500 000 women per annum and it is estimated that one out of every two women will die from CVD (American Heart Association Fact Sheet 2004:9). In spite of these staggering statistics, Legato et al (1997:189) found that women still perceive coronary heart disease (CHD) to be a man's problem and were not aware that CHD is the leading cause of death among women after the age of 50, in the USA.

Societal expectations also impact on gender and health. The World Health Organization (WHO) (1998:12) found that "the societal structure in which men and women function dictates their longevity, functional state of disease and the burden and outcomes of disease".

In Western societies, men are encouraged to enjoy risky behaviour. Deaths resulting from accidents, homicides and risk-taking behaviour are three times higher among young adult men than among

women. Men commonly have the work role as their primary focus and as they age depression rates are higher because their work role is diminished and they find themselves more isolated and lonely. Women, on the other hand, have multiple roles and so their adaptive style better prepares them for changes that occur as they age, thus enabling them to adjust and accept different roles. Women are unique because their roles in life are lifelong; what changes is the context in which these roles are accomplished and performed. Women as they age are more likely to have formed long-lasting friendships, a factor that plays a vital role in the later years when statistically they are likely to be single and living alone (Condon 2004:23). The US Administration on Ageing (2003:4) reports that according to the 2000 census, 80% of all older persons who live alone are women.

Longevity and the social context are not the only gender issues that influence women's health. Reproductive health events, such as menstruation, childbearing and menstrual function, have seen the development of services to meet the demands of these events. Women of reproductive age are encouraged to pursue a healthy pregnancy with services available in the public and private sectors. Screening for baseline anaemia, communicable diseases and foetal wellbeing are basic to these services. Gynaecological checks for early detection of cancer of the cervix and breast are considered essential to delivery of health services for women during the childbearing years.

While many women enjoy the sophisticated services provided by healthcare providers to meet the needs of the reproductive years, current research shows that as many as sixteen (16) million women in the USA are without healthcare insurance (Kaiser Family Foundation Health Facts 2002:1). Medicaid and Medicare provide a range of healthcare services for childbearing and post-menopausal women who are not covered by healthcare insurance. Medicare is funded by the federal government, and as such, provides healthcare to pregnant women, the indigent and those suffering from renal disease. Local district health departments offer screening services for childbearing women at minimal cost that enables them to receive family planning services, Papinicolae smears (PAP smears), the management of sexually transmitted diseases (STDs) and immunisation programmes. Volunteer agencies assist with the provision of screening services for cardiac health, mammography, cholesterol

and osteoporosis. Usually there is a minimum charge for these volunteer services and this is financially prohibitive for many women. While there is an appearance of provision of women's health services in the USA and more specifically in Boise, Idaho, the services are less accessible and available as women approach middle age. In addition, Medicare does not cover preventive and promotive health benefits as generously as for childbearing and post-menopausal women. Stieber (2002:14) refers to this as "fragmented coverage, sometimes referred to as 'legislation by body parts', which may be based more on the prevailing political winds than on new medical evidence". This has implications for women during midlife transition because the opportunities for preventive and promotive health services are significantly limited and dictated by politics and financial restraints. This affects the way in which these women experience healthcare and services.

Many of the normal physiological transition processes, such as menstruation and menopause, are managed as pathological conditions requiring mostly pharmaceutical interventions. Prior to the 1930s menopause was seen as a natural period of a woman's life, heralding the end of her reproductive years. The introduction and use of Premarin in the 1960s changed this midlife event into something pathological which needed to be managed and controlled as a medical condition. In 1962, the Food and Drug Administration (FDA) approved Premarin, an estrone-base drug, for safety and efficacy in controlling the symptoms associated with menopause (Fletcher, Graham & Colditz 2002:366). Since the 1970s the use of Prempro, a combined hormonal replacement therapeutic and Premarin, an estrogen dominant therapeutic, has resulted in the development of a multi billion dollar industry in the USA and globally (Fletcher et al 2002:366). Expanded use of the drug in 1982 encouraged long-term use of the drug for many women for cardio protection and the prevention of osteoporosis (National Women's Health Resource Center 2004:4). Marketing campaigns in the 1990s promoted the premise that the advantages involved in HRT outweighed any risks that may have be derived from the therapy. Women were encouraged to use HRT whether they needed it or not (Fletcher et al 2002:367).

The premature discontinuance of the estrogen-plus-progestin and the estrogen-only trials of the Women's Health Initiative (WHI) in July 2002, raised serious issues for women in midlife who were

confronted with the multiple risks associated with prolonged use of HRT (Writing Group for the Women's Health Initiative Investigators 2002:321). The study showed that the Premarin/Provera combination of HRT did not prevent heart disease, but had, in fact, contributed to an increased incidence. Not only did HRT not infer cardio protection as previously thought, the risk of estrogen-related breast cancers was, in fact, higher than previously posited. In addition, stroke risk was significantly elevated in all five years of the study (Kerr 2003:1). The FDA required that all companies that made the drugs with or without progesterone carry "a boxed warning - the highest level of caution in label warning" (Ministry of Health Media Release 2003:1). This resulted in a decline of the use of the drug by prescribing physicians, in addition, the number of women who elected not to continue use HRT increased significantly (Haskell 2004:438) This created a dilemma for the women concerned as they sought alternatives to manage the symptoms associated with menopause (Davis Cockey 2004:110).

Negative marketing of the menopause has resulted in the media portraying middle-aged women as depressed, emotionally unstable, intellectually challenged and less valued by the society in which they are placed. (Hardy & Conway 1992:23; Pogrebin 1996:21) Biomedical research has led to the assumption that menopause was an "unnatural consequence of the extension of the human lifespan" (Condon 2004:501). The inference was that the human body was ill equipped to deal with these biological changes. Research into the menopause is a recent development and is the result of the improved status of women in society and the burgeoning of women's health as a marketable entity (Condon 2004:501).

Previously, menopause was a subject little discussed openly, and for many women it was considered a taboo. Culture plays a significant role in this but it is outside the scope of the current study to discuss this. Currently in most of Western society, the subject is openly discussed and written about in books and magazines, particularly how to manage the symptoms of menopause and the use of various diets, natural remedies, and energy medicine. Health stores and doctors' consulting rooms provide information pamphlets suggesting ways in which women can manage the process. Marketing strategies are aimed at the symptoms of menopause and how to control them, the assumption being that the symptoms appear in

isolation of the social construct of the women who are experiencing them. The conclusions reached suggest that the symptoms are linked to a dysfunctional biological process rather than the complex life situations that may or may not impact on the lived experience of these women (Condon 2004:502).

According to the National Women's Health Resource Center (2004:7) in Red Bank, New Jersey, the opposite is actually true and women who manage their lifestyle can change the way in which they enjoy and experience health across the lifespan, particularly the midlife years. In a study on the perimenopausal process, Quinn (1991:25) found that women's self-care reports of the process had validity and that women were doing things that made a meaningful difference to the transition of midlife. In her book on menopause and creating physical and emotional health and healing during the change, Northrup (2003:7) refers to a 1998 Gallup Survey that found that 50% of women, aged 50 to 65 years, felt happier and more fulfilled than at any other time of their lives. This is in stark contrast to the way in which menopause is generally viewed and managed by the traditional medical model, which portrays menopause as a disease that requires management with pharmaceuticals, specifically HRT (Condon 2004:502; Lee 1996:23; Northrup 2003:133.) The "baby boomer" generation is living longer and it is argued by (Hodge 2004:2) that as these women reach midlife, statistically, they will live another twenty-five to thirty years beyond the menopausal transition. How they enjoy these years and manage their own health remains under-researched (Condon 2004:503).

While many of the changes in women's health service delivery and research may be helpful, the researcher found a paucity of research and literature on how women themselves actually experience menopause and, in that context, how they would go about managing their own symptoms and well-being. Matteson (2001:4) encourages healthcare professionals to hear what women are saying in order to learn about their lived experiences and in that way, to make a difference to the healthcare that the women receive. The purpose of this study is to explore how women undergoing midlife transition experience this period of change, and to develop a model for support of women during midlife transition.

According to the 2000 census, the population of the USA is approximately 250 million people. Women represent 49,2% of the total population; however, over the age of 60 years, one in every ten persons is a woman (US Census Bureau 2000:2).

The researcher conducted the present study in the Boise and Nampa metropolitan areas of Idaho. Idaho is a northwestern state with a total population of 1,3 million. The state is largely rural and, as such, is under-populated. Boise, situated along the Boise River in the foothills of the Rocky Mountains, is the capital and largest city and the hub of commerce, banking and government for the state. Geographically, Boise covers 1 645 square miles at an elevation of 2 842 feet and has a high desert plain that terminates at the Rocky Mountains.

The city of Boise is part of a thriving metropolitan area of 450 000 people. Women represent 49,2% of the total population (US Census Bureau 2000:2). Many large regional, national and international companies are headquartered here, including the Simplot Corporation, Boise Cascade, Albertsons, Micron Technology and Hewlett-Packard. The designated market population for Boise for the year 2000 was 538 800 persons. The city is serviced by diverse health facilities that include alternative health options, such as therapeutic massage, chiropractic services, naturopathic services and numerous health and wellness centres, which offer various options for the community at large.

The city of Nampa is located nineteen miles west of Boise and is the second largest city in the state with a population of 53 000. Nampa is predominantly rural but with several huge industrial plants, such as a cheese factory and sugar beet factory. The city is diverse culturally with a large Hispanic population, many of whom represent the labour force of the surrounding farmlands. Many residents from Nampa commute each day to Boise for work and social purposes.

The cities of Boise and Nampa have a population of 270 000 women, and 34% of these would be categorized as middle aged. The percentage figure is reflective of American society, where women outnumber men by 1,8% (US Census Bureau 2000:1).

1.3 PROBLEM STATEMENT

Condon (2004:500) states that women are the primary health providers in most households in the USA and use diverse methods to achieve health and wellness for their families and themselves. They are more likely to read what is available in the media; network with other women on what works and what does not; pay attention to what their mothers and grandmothers taught them, and find economical and efficient ways to achieve a state of wellness for their families.

According to Morris (1996:31), women in midlife are classically described as part of the “sandwich generation”. This is seen as a period when women have dual roles, caring for children, grandchildren and parents. However, the researcher found that it is not clear what it is that the women actually do to keep themselves in a state of health or how they experience this period of transition. Even less clear is how health professionals and, more specifically, nurses can support women during this stage of their lives. These questions led the researcher to formulate the following statement of the problem and research purpose and objectives.

1.4 PURPOSE OF THE STUDY

The main purpose of this study was to propose and describe a model for support of women experiencing midlife transition and menopause.

1.5 RESEARCH OBJECTIVES

In order to achieve the purpose, the researcher aimed to

- explore and describe women’s experience of midlife transition
- classify concepts of the model

- describe the structure and process of a model for support of women during midlife transition
- develop guidelines for operationalization of the model

1.6 PARADIGMATIC PERSPECTIVE OF THE STUDY

The researcher used a health promotion paradigm to allow her to develop a model for support of women during midlife transition and enable her to identify self-care strategies and health promotion behaviour that women in midlife may or may not employ.

According to Botes (1995:6), no study is value-free and for this reason researchers must make their assumptions explicit. Polit and Hungler (1999:605) describe assumptions as “principles that are accepted as being true on the basis of logic or reason, without proof or verification.” Researchers’ values direct their thinking and activities. Researchers select certain assumptions from the paradigm perspective in response to their interaction with the research field. In this study, the researcher made meta-theoretical, theoretical and methodological assumptions.

1.6.1 Meta-theoretical assumptions

Meta-theoretical assumptions are not testable and deal with the human being and society (Botes 1995:6). For the purposes of this study, the researcher employed concepts of feminist thought to enable her to “observe the lived experiences” of the women (Holloway & Wheeler 1996:132). This would also facilitate exploring the respondents’ social environment so that “the social reality of the health care situation can be researched to acknowledge gender issues rather than ignore them” (Ehlers 1999:27). The assumption is that there is a difference between reproductive sexual health and gender-specific health. Legato (2000:3) describes gender as more than a description of men’s or women’s health as a consequence of their sex, but “as that which is a result of their attitudes and social environment”. The WHO (1998:76), too, shifted its traditional view of women’s health to that of gender-specific health.

In addition, the ethical considerations inherent in interviewing women applied to the study because the in-depth interviews reflected the respondents' "their experience". Holloway and Wheeler (1996:3) refer to this as the "emic perspective". The emic perspective "explores the ideas and perceptions of the participants, the insider's view" (Holloway & Wheeler 1996:3). Because the researcher is a woman, a feminist view allowed the development of a reciprocal relationship with the women participating. Bryman and Burgess (1999:55) refer to Oakley's (1981) description of this as a "non-hierarchical" relationship. The researcher's intent was to develop a model that best reflects support for women in midlife transition. This paradigm assisted with the exploration of experiences, which are uniquely those of women.

1.6.2 Theoretical assumptions

Theoretical assumptions are testable and offer epistemic pronouncements about the research field. Theoretical assumptions give shape to central theoretical statements as well as to the conceptual framework of the study (Botes 1995:6). This study, then, assumed the following:

- Women's health is viewed as a process of health care determinants and strategies specific to women rather than those framed on the male model.
- "Gender-sensitive medicine" is the more correct term for discussing women's health strategies that may be unique to women's biology and physiological responses.
- "Person" means a woman who is in midlife.
- Support refers to the nursing actions aimed at promoting health among menopausal women. The nursing actions are more encompassing, however, than those associated with the curative nature of nursing and include alternative therapies and therapists valued by the women concerned.
- The environment specifically pertains to the context in which these women are to be found and may include the geographical areas, the social confines as well as the economic boundaries which may impact on them and in which they experience well-being.

1.6.3 Methodological assumptions

According to Botes (1995:7), methodological assumptions concern researchers' view of the nature and structure of science and research in their discipline. The central assumption is that research should be functional and the knowledge thereof applied in practice. In this study, the researcher wished to gain knowledge about the experience of midlife transition in order to develop a model in order for nurses to support women in this age group.

1.6.4 Definition of terms

For the purposes of this study, the following terms are used as indicated below.

- **Wellness.** Hurley and Schlaadt (1992:6) define *wellness* as "an approach to personal health that emphasizes individual responsibility for well being through the practice of health-promoting lifestyle behaviors".
- **Health.** The WHO (1958:1) defines *health* as "a state of complete physical, mental and social well-being and not merely the absence of disease".
- **Self-care.** Pender (1996:97) defines *self-care* "an ongoing activity for individuals and groups that is required to sustain life and health". It includes those activities that are self-directed and for which the individual takes responsibility. It may also include alternative therapies.
- **Chronic disease.** *Chronic disease* refers to "the long and persistent development of a health problem over a period of time" (Edelman & Mandle 2002:710).
- **Menopause.** Mitchell, Woods and Mariella (2000:334) describe *menopause* as "six to twelve months elapsed time since the last normal menstrual cycle".
- **Midlife transition.** Mitchell et al (2000:335) describe *midlife transition* as "40 to 55 years of age".
- **Surgical menopause.** *Surgical menopause* refers to induced menopause, due to the abrupt cutoff of ovarian hormones as a result of bilateral oophorectomy. This will result in the sudden onset of

hot flashes and other menopause-related symptoms. Replacement Hormone Therapy (HRT) is considered mandatory (Legato & Colman 2000:24).

- **Model.** Chinn and Kramer (1995:216) define a *model* as "a symbolic representation of perceptual phenomena in words".
- **Support.** *Webster's Collegiate Dictionary of the English Language* (2002:740) defines *support* as "to give assistance or approval to, or to uphold".

1.7 RESEARCH DESIGN AND METHODOLOGY

1.7.1 Research design

The researcher selected a theory-generative research design that is qualitative, explorative, descriptive and contextual.

The methods of theory generation of Chinn and Kramer (1995) and Dickoff, James and Wiedenbach's (1968) were applied in this study. These methods consist of four steps:

- Concept analysis (concepts will be identified, defined and classified)
- Construction of relationship statements
- Description of the model
- Guidelines for the operationalisation of the model

1.7.2 Research methodology

In order to generate theory, the researcher first explored and described the experience of midlife transition of women so as to identify the main concept(s) of the model. Concept analysis, involving

concept identification, definition and classification, was conducted to identify model concepts. In-depth phenomenological interviewing was selected as the data collection technique.

1.7.3 Ethical requirements

The issue of ethics in qualitative research creates a dilemma. Informed consent, immersement and influence remain complex and controversial (Holloway & Wheeler 1996:42). The flexible nature of the qualitative paradigm impacts on informed consent. According to Holloway and Wheeler (1996:43), "informed consent is not once-and-forever permission but an ongoing process of informed participation". Robinson and Thorne (1988:65) maintain that influence can change the findings while studying them and further that informed consent is problematic because data collection and analysis occur simultaneously.

In this study, the researcher observed the following ethical considerations to protect the rights of the respondents:

- The research proposal was submitted to the University Committee at the University of South Africa (Unisa).
- An Institutional Research Board (IRB) form was submitted to Northwest Nazarene University, Nampa to ensure a local source of reference for the participants should they so desire (see Annexure 6).
- Permission was sought from the venues where women were recruited, including the Eagle Public Library, St John's Episcopal Church, and Paul's Super Market chain in Nampa.
- Written permission was obtained from all respondents (see Annexure 3).
- The researcher was the primary research person, which ensured confidentiality, consistency and reliability.
- Participants were assured that if they wished to withdraw from the study at any time, they might do so and would not be intimidated or coerced to continue by the researcher.

- Permission was sought for the use of a recording device (tape recorder) and the participants asked to sign consent (see Annexure 3).
- Data was secured rigorously to ensure that confidentiality was maintained.

Conclusions and interpretation would arise from the collected data. The rights of participants were respected in accordance with the University's code of ethics for research.

1.7.4 Sample population

All women who met the criteria (see section 1.7.5) in the Boise and Nampa metropolitan area represented the sample population. The researcher used purposive sampling, which means that the "participants are selected based on certain criteria for a previously specified purpose" (Holloway & Wheeler 1996:76). Women were approached to participate in in-depth interviews for inclusion in the study. They were recruited by using flyers at the local library and local grocery stores in Nampa and Boise in order to ensure representivity of social and economic class, culture, and religious persuasion.

The researcher conducted phenomenological interviews at venues suitable to the respondents and in an environment conducive to private, non-threatening and non-interrupted conversation. In keeping with the qualitative paradigm, flexible sampling enabled the addition of participants to the study to achieve representivity (Polit & Hungler 1999:101).

1.7.5 Sampling criteria

All women in the State of Idaho represented the population. The target population included women between 40 and 55 years of age. This included women in midlife who were more likely to have completed the task of childbearing and to have experienced diverse self-care strategies.

Women who had experienced surgical menopause were excluded. The impact of long-term HRT would bias these women's perceptions and experience of the symptoms and/or the management of menopause.

Purposive sampling ensured that only women who met the inclusion criteria were included, namely age, gender and the ability to communicate in English.

1.7.6 Data collection

The researcher collected data during the course of 2003 and 2004 and continued until saturation was achieved to enable a thick description of the respondents' lived experiences.

To enhance the context and confirm suitability for inclusion in the study, the women were asked to fill out a short biographical information sheet (see Annexure 2). Information included age, education, a brief medical history, and lifestyle information such as exercise, diet and nutritional supplements taken.

In-depth individual interviews were conducted with all participants. Prior to interviewing, the participants were asked to complete a written consent form (see Annexure 3). Confidentiality, privacy and anonymity were maintained by ensuring that the names of participants were guarded, the raw data kept securely locked in a file cabinet to prevent unsolicited viewing and the audio tapes destroyed after transcription of the data.

□ In-depth phenomenological interviews

The researcher conducted in-depth interviews with women recruited into the study. Interviewing allowed the respondents confidentiality and an opportunity to develop a relationship with the researcher. This was essential for them to share their lived experiences and tell their stories. Morse (1991:127) states

that interviews also allow for “informants sharing characteristics”. The respondents were asked: How do/did you experience your midlife period? What strategies did/do you employ to manage the symptoms of menopause. Harding (1987:8) debates the concepts of “discovery” and “justification”, stating, “researchers should recognize that the participant questions asked are at least as important as the answers obtained”. The interviews were tape-recorded to enable accurate and complete transcription of the interviews. Morse (1991:127) stresses that reaffirmation of concepts and clarity of themes should be “sought from useful informants during in-depth interviews until no new data arise”.

□ **Field notes**

Field notes were used during and immediately after the interviews to describe the context and clarify non-verbal cues during the transcription process. This enabled the researcher to achieve a thick description reflecting not the discussion as well as the context.

□ **Pilot study**

The researcher conducted a pilot study to establish and identify the suitability of the selection criteria, determine whether the central question elicits the information sought, and clarify any ambiguity as well as the depth of answers required. This was intended to enhance the respondents’ perception of the researcher as more than just a data collector.

1.7.7 Data analysis

To assist with the identification of the essence of the phenomenon, the researcher did latent content analysis to identify recurrent themes. The researcher read and reread the transcripts several times to immerse herself in the data. Interview transcripts generally result in the generation of unstructured data. Creswell (1994:154) recommends the use of Tesch’s (1990:25) eight-step analysis model and states further that an eclectic approach is helpful in data analysis.

Reading the transcribed interviews several times allows topics/concepts to emerge and be grouped together to identify categories. Categories that relate to each other are then grouped together. Burnard (1991:462) describes this as organizing the categories under “higher-order headings” to collapse them so that similar categories are blended together into broader categories.

In addition, the researcher asked a colleague to review some transcripts to affirm recurrent themes and concurrent review of the literature assisted with confirmability.

1.7.8 Literature control

Polit and Hungler (1999:44) state that themes that emerge from the results should be examined and discussed in the light of relevant literature and information obtained from similar studies. Accordingly, the researcher did this in order to identify the similarities and differences between this and previous studies, and the potential contribution of this study.

The researcher employed deductive reasoning to identify and define the concepts (see chapter 2 for a full discussion). Dickoff et al (1968:437) methodology was used to classify and describe the concepts (see chapter 2). According to Chinn and Kramer (1995:106), theory definition includes identifying the purpose of the theory and the concepts that emerge; developing the definitions that give the theory meaning; identifying the relationships that link the concepts to enable the components of the theory to connect thereby giving it structure. Finally, Chinn and Kramer (1995:106) point out that assumptions are fundamental and necessary for the description of theory. These may be implied or explicit.

1.7.9 Support model

The concepts that emerged from the interviews and literature review assisted the researcher in developing the support model and formulating the guidelines for its operationalization. The model and guidelines were evaluated by nursing experts (see chapter 2).

1.8 TRUSTWORTHINESS

According to Holloway and Wheeler (1996:162), trustworthiness exists “where the findings of a qualitative study represent reality”. Qualitative research requires rigor and trustworthiness, which is demonstrated by an audit trail. Polit and Hungler (1999:696) define an audit trail as “the systematic collection and documentation of material that allows an independent auditor in an inquiry of qualitative data to draw conclusions about the data”. To demonstrate rigor and ensure trustworthiness, an audit trail will be demonstrated in the following manner:

- Raw data such as field notes and interview transcripts will be kept
- Theoretical notes from data reduction and analysis will be maintained
- Methodological notes resulting from member checks will be maintained

The researcher used Guba’s model for trustworthiness with the four criteria of truth-value, applicability, consistency and neutrality to ensure the validity and reliability of this study (Lincoln & Guba 1985:291) (see chapter 2).

1.9 OUTLINE OF THE STUDY

Chapter 1 introduces the study and outlines the background to the problem, the purpose and aim of the study.

Chapter 2 describes the research design and methodology.

Chapter 3 discusses the research findings and literature review.

Chapter 4 describes the development of a model for support of women during midlife transition to menopause.

Chapter 5 describes the model structure and process.

Chapter 6 presents guidelines to operationalize the model in practice.

Chapter 7 concludes the study, briefly discusses its limitations and makes recommendations for further study.

1.10 CONCLUSION

This chapter described the background to the study, the purpose and aims of the study, the research design and methodology, data collection, ethical considerations and measures to ensure trustworthiness.

Chapter 2 discusses the research design and methodology.