CHAPTER 3

Research findings and literature review

We must become the change we want to see.

Gandhi (1927)

3.1 INTRODUCTION

Chapter 2 described the research design and methodology of the study. This chapter covers the results obtained from the data collected from women who have experienced midlife transition (see Annexure 7 for an example of a transcribed interview) and the literature review. According to Field and Morse (1985:106), the literature provides a mechanism that assists in demonstrating the usefulness and implications of the findings. Consequently, the researcher conducted a literature review in order to

- verify the identified themes
- establish whether the identified themes have previously been documented
- re-contextualise the data

3.2 SAMPLE DESCRIPTION

The sample consisted of women from two cities of southwest Idaho in the USA. Purposive sampling was chosen as the technique as this permitted the deliberate inclusion of women who met the criteria set (see chapter 2). The researcher approached women to be included in the sample. This resulted in "snowball sampling" when the women themselves suggested other women to be included in the research. Polit and Hungler (1999:281) describe snowball sampling as a type of convenience sampling

also referred to as “network sampling” because women in the sample are asked to refer other women with like characteristics and criteria that meet the study requirements. This assisted with including women who fitted the age and other criteria used (see chapter 1). The benefit of snowball sampling to this particular study was to enable the inclusion of a Hispanic woman and women of the Mormon faith because they represent the majority of women in Idaho. Thus, all social classes and cultures were included in the sample. The women were all in midlife years and the average of the group was forty-eight years. Most of the women were White and middle class but the purposive nature of the sampling permitted the inclusion of a Hispanic woman.

A brochure was placed in a supermarket in Nampa to elicit Hispanic-speaking women. This was done because the majority of the working class in the city is Hispanic. Exact statistics are not available as many of these people are considered permanent seasonal workers and, as such, work and are resident under special circumstances, therefore are not included in the population count. In addition, many of the migrant workers are illegal and therefore they would keep a very low profile within the community in which they work. This was not a successful approach. A Hispanic woman was personally recruited via a colleague to be included in the study.

All the women spoke English and for most of them it was the language of choice at home. Idaho is home to a large Mormon population; it has the second largest number of members worldwide and because of this, the researcher intentionally recruited a woman who was known to be a member of this faith. The Church of Jesus Christ and Latter-Day Saints (Mormons or LDS) are a closed community therefore it was imperative that the views of this group were represented. This resulted in other women from the group being recruited for the study. The number of years of education varied for the group with the majority having graduated from high school. The group included professional women, women who worked in clerical and administrative posts, and women who had elected to stay at home (home keepers) (see table 3.1).

Table 3.1 Demographics of women in midlife (N = 8)

	N = 8	MEAN (%)
Years of Education		
High school graduate	8	100
Two years' college	2	25
College graduate	1	12,5
Graduate degree	0	-
Age		
40-45 years	2	25
46-50 years	5	62,5
51-55 years	1	12,5
Profession		
Home keeper	1	12,5
Professional women	3	37,5
Commercial environment	4	50
Marital status		
Married	8	100
Divorced	1	12,5
Widowed	0	-
Remarried	1	12,5
Never married	0	0

The women all filled out a biographical data sheet (see Annexure 2). There was no evidence of pathology or chronicity in the sample of women in the study. The women perceived themselves as essentially well in spite of some identified risks and potential underlying pathology, such as cardiac disease. It is important to note that in response to question 5 on the biographical data sheet, most of the women indicated that they did not use self-care strategies. The use of diet, exercise and supplements, however, emerged as a theme throughout all the interviews. The women did not appear to perceive these practices to be self-care but rather part of a normal lifestyle.

3.3 RESEARCHER'S EXPERIENCE OF FIELDWORK

The researcher is a woman in midlife transition thus it was with some ease that she was able to identify with the experience that the women were sharing. However, this required that the researcher bracket out her prejudices, values and beliefs. The researcher does not share the experience of many of the symptoms that the women reflected, but does relate to the self-care strategies that the women in the study mentioned. In this regard, the researcher follows a dietary and exercise regimen and, in addition, uses herbal supplements to offset any of the symptomatic changes that may occur.

The researcher interviewed all the women in the study. The researcher found the interview process difficult initially because of her clinical background, which resulted in her wanting to accomplish an assessment of the women being interviewed. To curtail this, the researcher used bracketing and memos. Some of the interviews were more difficult than others and, in particular, the group of women from the Mormon faith appeared intent on proselytizing the researcher. This would be in keeping with their faith practices therefore the researcher did not find this offensive or intrusive.

Eight interviews were conducted over a period of fourteen months. Each woman met the criteria for inclusion in the study (see chapter 2). An appointment was made with each participant and she was asked to read an information sheet (see Annexure 1) and complete a biographical data sheet (see Annexure 2). The women were all asked to sign consent (see Annexure 3). This permitted tape-recording of the entire interview. The participants were asked to complete two tasks, namely to complete the short health questionnaire and to describe their experience of midlife transition. Most of the interviews lasted an hour or less and were at venues suitable to the women concerned. Several of the women asked to use the researcher's home as a venue as they deemed this more private and quiet. The researcher does not have children in the house and when the interviews were undertaken, the home was empty. Each interview was transcribed verbatim.

Each interview was analyzed using the Tesch model of analysis (Creswell 1994:155). Transcripts were read and reread several times, as the researcher underlined words and concepts that appeared and reoccurred. Interview 2 was randomly chosen and underlying meanings were jotted in the margin (step

2 of Tesch analysis). All the transcripts were then read and topics that emerged were noted. This assisted with the identification of similar categories and sub-themes. The researcher also made use of coloured stickers to differentiate the emerging topics, which were then categorized into themes and two themes, then emerged. The researcher is a visual learner and the colours enabled her to see patterns of repetition. In order to enhance the trustworthiness of the analysis, an independent researcher was asked to analyze one of the scripts and identify the emerging themes. These were compared with those already identified by the researcher's analysis. Consensus was reached between the independent researcher and the researcher regarding the experience of women in midlife transition.

Categories, sub-themes and themes were discussed with a panel of experts in qualitative research in order to enhance trustworthiness. The researcher kept field notes. These were integrated into the themes and discussion thereof.

All the women interviewed were willing to discuss their experience but at times during the interview, the interviewees needed reassurance that their thoughts and discussion would remain confidential. To maintain the confidentiality of these women, their names have not been used in the retelling of their stories. They are referred to as "women" or "participants" and this was done to maintain anonymity and confidentiality.

Table 3.2 represents the themes and sub-themes and categories of the experiences of women in midlife transition.

Table 3.2 Themes and categories of the experiences of women in midlife transition

THEME	CATEGORIES	SUB-CATEGORIES
3.4.1 Women in midlife experience the process of change as normal transition	3.4.1.1 Women relate the physical changes that occurred during midlife that impacted negatively on their lives	The women's physical experience of midlife transition: 3.4.1.1.1 Skin becoming wrinkly and dry 3.4.1.1.2 Thinning and graying of hair causes anxiety 3.4.1.1.3 Weight gain as the women age 3.4.1.1.4 Sleep disturbances that cause chronic tiredness and decreased energy 3.4.1.1.5 Decreased and increased sexual libido from the change in hormonal function
	3.4.1.2 The women experience psychosocial changes that impact on their experiences of midlife transition	The women experience: 3.4.1.2.1 A change in roles, some new roles and roles that have previously emerged but changed during midlife 3.4.1.2.2 A sense of independence in being able to focus on what is important for them 3.4.1.2.3 Contentment and being happy with where they are in their lives 3.4.1.2.4 A positive self-image because they do not view themselves as different 3.4.1.2.5. A positive self-esteem with the women actually expressing satisfaction and liking for themselves 3.4.1.2.6 A fear with hormone-related issues
	3.4.1.3 The women experience midlife as a time for spiritual growth and awareness as well as a time to reflect on what has gone and what is to come	The women experience: 3.4.1.3.1 A deeper commitment to God 3.4.1.3.2 God working in life with divine control 3.4.1.3.3 An awareness of their own mortality and their views on death 3.4.1.3.4 Having more time to communicate and pray with God
3.4.2 How the process of midlife change and transition is managed by women in midlife	3.4.2.1 The women experience negative and positive relationships with health care providers	The women relate: 3.4.2.1.1 The positive relationship experienced by women that reflected confidence and beneficence 3.4.2.1.2 The negative experience of the healthcare relationship that made the women feel that the care providers were rushed and inattentive and at times, untruthful
	3.4.2.2 The women experience the need to use numerous self-care strategies to maintain a healthy lifestyle	The women used: 3.4.2.2.1 Diverse exercise regimens, which were all unstructured and self-directed 3.4.2.2.2 Diverse natural supplements without discussion with healthcare providers 3.4.2.2.3 Diet regimens to assist with weight loss and weight gain prevention and hormonal balance 3.4.2.2.4 Promotive and preventive screening strategies that included items not suggested by medical insurance

Figure 3.1 represents the themes and categories that emerged from the data.

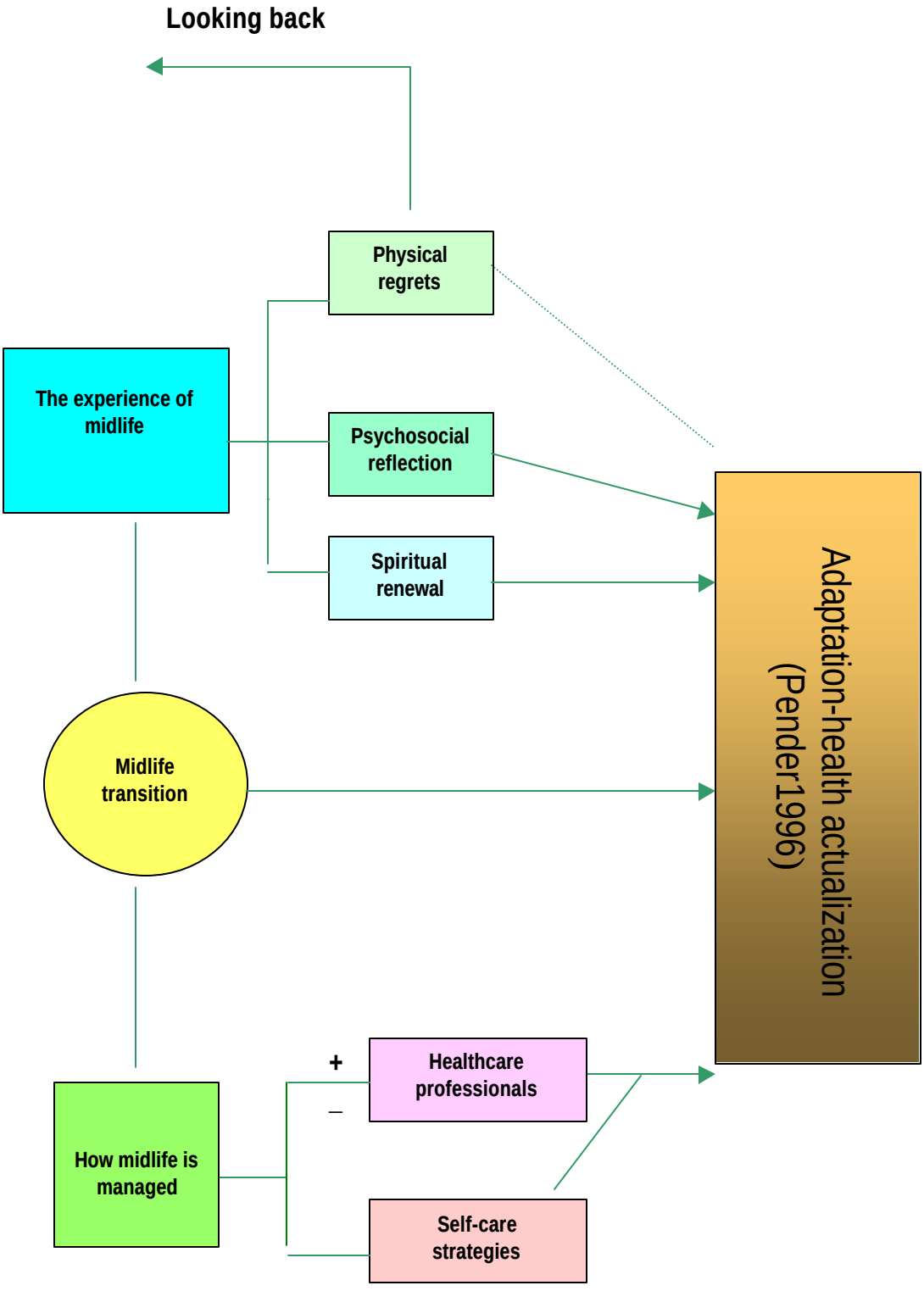
Looking back
Physical regrets
The experience of midlife
Psychosocial reflection
Spiritual renewal
Midlife transition
How midlife is managed
+
–
Healthcare professionals
Self-care strategies
Adaptation-health actualization (Pender1996)

Figure 3.1

Themes and categories that emerged from data

Table 3.3 depicts the sub-categories and categories that emerged from the interviews and how the sub-categories were reduced to five categories from which two themes emerged.

Table 3.3 Sub-categories and categories that emerged

SUB-CATEGORIES	EMERGING CATEGORIES
Skin changes Hair changes Weight gain Libido changes Sleep disturbances	The physical changes experienced by the women
New roles Independence Self-image Self-esteem	The psychosocial changes that the women experienced
God time Prayer Mortality Commitment	Aspects of spiritual growth and awareness experienced by the women
Physicians Knowing best Communication behaviours	The relationship of women with health care providers
Exercise Diet Supplements Screening strategies Tests	How the women use self-care strategies

3.4 WOMEN'S EXPERIENCE OF MIDLIFE TRANSITION

Two themes emerged in this study: (1) how the women experience the process of normal change and transition during midlife, and (2) the ways in which the women manage this period of change and transition. Sub-themes related to the lived experience of midlife that emerged were: the physical changes that occur during midlife experience, the psychosocial experiences of the women during this transition, and the experience of spiritual growth and awareness.

3.4.1 Women in midlife experience the process of change as normal transition

Northrup (2003:37) states that a woman's health is bound to the culture in which she lives as well as the way in which she views herself, her life and her perspective on what health constitutes. George (2002:78) adds that menopause is not only dependent on culture but also on personal knowledge and what is socially learned. This implies that women have what George (2002:78) calls "preconceived ideas about menopause". The interviews from this study reflect this. The women all viewed themselves as healthy and had definite perspectives on what midlife was and was not for them personally.

Although all the women mentioned symptoms, none of them viewed these as life-threatening or pathological but rather as part of the normal change and process. All the women repeatedly referred to "normal change", even when describing symptoms causing distress and anxiety.

Change is part of life. Marsden and Ridlen (2003:FS981) state that change is the one thing in life that is certain, no one escapes change. *Webster's Collegiate Dictionary of the English Language* (2002:118) defines change as "making different or altering". *Encarta World English Dictionary* (1999:304) defines change as "the act of becoming something different or to move from one state to another". This, then, suggests that change is to transition from one state to another. The change process involves the steps that have to be taken to accomplish or achieve change. It can only take place once a person recognizes the need to change.

Developmental change, as in midlife transition, is expected change because the change is presumed to occur within a determined time and framework, therefore it is more predictable. This may account for why the women in the study perceived the change process as "normal". Normal is a subjective term, which, *Webster*'s *Collegiate Dictionary of the English Language* (2002:493) defines as "conforming to a type or standard". Normal may also be associated as the average for the event or item being described. In this case, the women appeared to use their own experience and feelings to determine what was normal for them as reflected in "*I don't feel any different, I feel normal*." In spite of expressing feelings of normality, the women did verbalize several physical changes that required adjustments and, in some cases, caused concern.

3.4.1.1 Physical changes

All the women experienced physical changes such as skin changes, hair loss, sleep disturbances, weight gain and changes in sexual activity.

- **Skin changes**

The women noted the various changes that occurred physically, including skin changes, change in libido, and sleep changes. Skin changes related to ageing, such as wrinkles and dryness. One woman said, "*I think it sucks! I hate what it is doing to my skin*." Skin changes occur as a result of several factors. A decrease in hormone levels will result in the collagen layer of skin becoming thinner (Northrup 2003:332). The protective layer or epidermis of the skin is constantly being shed and replaced. The sloughing off of old cells is essential to a healthy skin and as a person ages, this process slows down; the resulting effect is that of dry and dull skin. Environmental factors, such as time spent in the sun, smoking and unclean air, may influence skin changes. The National Women's Health Network (2000:4) found that even with HRT, skin changes are significantly different in women who are smokers, for they are twice as likely to have wrinkling and color changes. None of the women smoked, yet changes were noted in spite of this. Little, if any, mention was made of the color changes in menopause

described by Legato (2002:54), Northrup (2003:333) and Lee (1996:253). Lee (1996:253) outlines several common skin problems related to hormonal imbalance, such as acne, rosacea, psoriasis and keratosis, in addition to the ageing effects of wrinkles and liver spots. Women in the study only expressed concern with wrinkles, dryness and the sagging of their skin.

> *The problem I have with midlife is what the body does at this time. It's really hard because I don't feel like I am really old yet. I know that I am not a spring chicken but I just don't like what the body does! You know, the drooping, the wrinkles, um, just what your skin does. I guess I am a little vain, you know, I just don't like that part at all!*

Much of today's advertising is concerned with youthful skin and ageing, which has led to the "attractiveness stereotype" that states that a youthful skin is beautiful and that what is beautiful, is good. The signs of ageing are assumed to make one less beautiful physically and, therefore, not "good." The opposing feminist view embraces the philosophy that skin changes reflect the experience of one's life. Pogrebin (1996:134-136) points out that "wrinkles are after all, time's signature, etched proof that one has lived". In addition to the skin changes that occurred, female androgenic alopecia caused anxiety and distress for many of the women.

- **Hair loss**

Some of the women experienced hair loss. This is attributed to hormonal imbalance and is typically described in the literature as "female balding pattern" or "female alopecia". A deficient level of the hormone testerone is thought to be responsible for this (Northrup 2003:333). Although the women referred to grey hair and the need for color touch ups, many noted that their hair was dry and brittle. However, the most worrisome concern for the women was androgenic alopecia.

The doctors don't seem as much concerned with the hair loss and the anaemia as they do with the underlying cause. I think maybe they think that because once that problem is cleared up, everything will be cleared up … but frankly, I am concerned about my hair! Every time we go out, I ask my husband, "Can you see my little pink scalp anywhere?" I feel something bad will happen if I don't do something … if it gets worse and worse I might really die or at the very least all my hair will fall out!

That's one of the things that got me off my hiney to go to a different doctor to find out what the problem was. I just, you know, I don't even like to go in my bathroom anymore because there is just hair everywhere, so now every time I do my hair I vacuum! My husband said he has never seen me vacuum so much. I … oh well, I just need to vacuum. I just don't like seeing all of me all over the bathroom floor!

Hair loss may contribute to some loss of self-esteem. Northrup (2003:356) suggests that this is a vital component of how the women feel about themselves and therefore may result in feelings of anxiety, depression and a lack of self-confidence.

Another anxiety-causing experience for many women in midlife is the change in sleep patterns. These were experienced as not being able to sleep or as being wakeful in the early hours of the morning.

- **Sleep changes**

All the women mentioned significant sleep pattern changes that not only included wakefulness during the night but also difficulty in getting to sleep at night.

Yeah, I have bad nights, not always, just unable to get to sleep. My husband sleeps like a log while I lay awake. There are nights that I have a totally sleepless night but not often.

Sleep is a problem! I don't manage to sleep well through the night now.

Um, that's gotten worse with age. I sleep in fits and starts. One would think, as you get older that sleep is more necessary but I notice with my parents that they sleep less than I do! I wake up at 3 and 4 in the morning, but then I want to sleep in the afternoon too.

While the physiology of sleep disturbances remains unclear, Bliwise, King, Harris and Haskell (1992:49) found that 20 to 40 percent of women over the age of 50 are likely to have sleep disorders. In addition, women are more likely than men to have insomnia after 35 years of age. Walsh (1992) (in Chokroverty & Daroff 1999:110) found that menopausal women appear to have a greater sleep need than men of the same age. According to Northrup (2003:296), the sleep changes are similar to those experienced in adolescence and for many women insomnia and fatigue are related to unresolved emotions and anxiety, which accompany the changes that occur during menopause. Lee (1996:124) maintains that sleep disorders in midlife are related to adrenal overload and the drop in levels of corticosteroids. This is linked to a significant drop in the progesterone levels of women in this age. The sleep disturbances probably encompass all of the above, in fact, but what is important is that fatigue will increase the likelihood of mood dyphorias and anxiety.

I found that maybe the past three years and maybe more frequently in the past, I wake up almost, you can set your clock by it, at 2:30 am. The doctor said that the topical progesterone will mitigate that problem.

Lee (1996:126) recommends that women apply a natural progesterone cream at night as progesterone is known to enhance sleep. None of the women in the study admitted to using any sort of sedation to assist with the problem and appeared to be resigned to sleep problems being part of the normal process. Therefore they managed them as best they could. The management strategies employed included excluding caffeine in their diets, reading, and exercise prior to retiring.

- **Weight gain**

Weight gain in midlife is common (Mayo Foundation for Medical Education and Research (MFMER) 2003:1) and all the women in this study experienced weight gain. Moreover, it caused some degree of anxiety to all of them. While many factors contribute to weight gain in midlife in both men and women, the major contributing factor in women is purported to be estrogen and a decrease in the plasma level of the hormone. Some slowing in metabolism and a decrease in the amount of body muscle also contribute significantly. Grambs (1989:47) argues that fat accumulation after midlife may have beneficial effects among which is that osteoporosis is less likely in women who have more fat (not obese).

> *I just think the weight gain; I just totally blame it on the hormonal thing. Maybe that's not the right thing to do but I just do. It just seemed like boom all of a sudden I had no metabolism and I could go to sleep and wake up two pounds heavier!*

> *I gained weight with my kids and I just kept gaining weight steadily. I am really struggling. I have been watching what I eat and probably the exercise.*

> *I think my metabolism is the problem. It's probably a zero number and so I am trying to do weight training to get my metabolism up.*

Lee (1996:138) describes weight gain as largely a result of adrenal malfunction, specifically an increase in the cortisol levels. In a study of Seattle midlife women's health, Woods and Mitchell (1999:167) found that the cortisol levels were unstable during midlife transition. All the women in this study referred to weight gain and the need to watch their diet. One participant in this study had undergone liposuction to manage the problem of a growing midriff:

> *In fact I had liposuction, um … that was real hard for me because I have never had a weight problem for years and years. In fact, when I hit about ten years ago I started seeing it coming on slowly and I never had, I don't have much discipline now because I never had to have it as a young*

person. And I put on about 10 to 15 lbs and it all went right to my stomach and I hated that! That was very hard for me.

Midriff fat deposition is more commonly seen in midlife and may be seen as a risk factor for future disease profiles such as diabetes. In addition to the physiological factors that contribute to weight, sedentary lifestyle patterns and disrupted mealtimes because of family demands play a role in weight gain. Seed (2002:54) indicates that the estrogen connection for weight gain is more significant than previously thought. A decrease in the ratio of estrogen to androgen production leads to a number of metabolic changes, including altered fat distribution and increased insulin resistance; this is thought to be responsible for the increase in weight. The Mayo Foundation for Medical Education and Research (MFMER) (2003:1)) states that the end of a woman's reproductive life is associated with significant body weight gain.

- **Changes in sexual activity**

Apart from weight gain, the women also referred to changes in sexual activity. These related to a change in libido and dysparnuia because of vaginal changes. Three signs are associated with the direct reduction in estrogen production, namely changes in the menstrual cycle, hot flashes and vaginal changes (Boston Women's Health Book Collective 1998:47). Vaginal changes are considered contributory to decreased sexual activity because of dysparnuia and a delayed arousal time (Legato 2002:203). Anatomical changes that result from a drop in estrogen may be narrowing of the introitus of the vagina and decreased blood flow to the genitals which decrease the normal arousal response time (Mayo Clinic 2003:1). According to Grambs (1989:57), in addition to the physical changes, the concept of desirability impacts on sexual behaviour in women during midlife. Women as they age are socialized to believe that after 50 they neither need nor deserve a sex life. Masters and Johnson (1966:25) state that sexual interest does not decline in women as they age, no more than it declines in men. In the present study, most of the women complained of a decreased libido related to a delayed sexual arousal and also to tiredness. Several women mentioned that sex was painful and Lee (1996:75) and

Northrup (2003:279) describe this as resulting from a dry vagina. One woman commented, "*I think that the physical made it difficult … and the physical is still there, you know. We have just learned to deal with it."* When asked to clarify what "physical" meant, the participant replied that intercourse was painful. Decreased libido is described in the following exemplar:

> *I have a marked decrease in sexual desire. I think I do, um, I just don't get as interested. It hasn't really caused a problem in our marriage because I don't ever refuse my husband but I don't get as excited about it as I used to.*

A few women mentioned an increased libido and this was attributed to different things, such as independence and privacy resulting from the children leaving home had improved their sex life.

> *I assumed that as we got older that sex would not happen as often, and I haven't found that … and you know, my husband may not think so! I think that we have the same amount of sex as we always have had and that is good for both of us. We have a really good relationship and marriage. It may be that we get tired more now than we used to but then in some ways we have more freedom because the kids are not home often and that makes it more private, if you know what I mean.*

Legato (2002:204) is of the opinion that sexual activity and exchange is more situational than hormonal and that if the circumstances are conducive, most women will enjoy good sexual exchange. One of the participants found that she was more easily aroused and felt slightly irritated that her husband did not share the same enthusiasm:

> *There may have been times in my life that I may have had a lower libido than his. Now, for some reason, mine just … I am not saying all of a sudden, but I mean, I seem to have a little bit more libido than he does. Now he is just too tired, plain too tired!*

The impact of physical changes among the women interviewed was varied and this should be seen in the context of their social being as well as the psychosocial changes they may or may not have experienced.

In addition to the physical changes, psychological changes also occurred: role changes, independence, contentment, and improved self-esteem. At the same time, however, some fears pertaining to death and mortality were also expressed.

3.4.1.2 Psychosocial changes

The media, to a large degree, portrays women in midlife as out of control, difficult and psychologically disturbed. This perception may in large part be the result of the impact of hormone replacement therapy (HRT) marketing, that portrayed women as "cranky, sexless and old" and in order for them to remain "forever feminine," hormone replacement was absolutely essential (Lee 1996:23). In 1966 Premarin (a synthetic form of estrogen) became the top prescribed drug in the USA. In 2000, 46 million prescriptions were written for the same drug, earning the company in excess of $1 billion in sales (Shelby 2002:20). In order to maintain the momentum of this marketing process, women were portrayed negatively in midlife and what emerged was a pathological condition, known as menopause. In addition, hormone replacement therapy (HRT) was marketed as essential to ageing women in order to add cardio protection and prophylaxis against the onslaught of osteoporosis. The abrupt termination of the Prempro arm of the Women's Health Initiative in July 2002 disputed many of these claims and women were thus forced to look for other means to manage what has commonly been called hormonal imbalance. Northrup (2003:42) refers to this as "debunking the myth of raging hormones". In spite of this, women are still perceived as being emotionally unstable during midlife transition. Psychosocial changes identified from the interviews in this study were changed roles, the impact of being a grandmother, contentment, independence, changes in self-esteem and self-image, and the importance of moving on with their lives. All the women expressed fears related to HRT and mortality issues.

- **New and changing roles**

Condon (2004:11) describes the multiple role changes required of women as necessary to the development of their self-concept. Women in midlife transition perform multiple roles, including spouse, mother, grandmother and parental caregiver. Many of these roles bring pleasure and satisfaction but at the same time, stress and responsibility. One woman in the study described her grandmother role with pride and joy:

> *I love being a grandma. Even on our website for our job we have our picture and you had to give your biography so I put there, my name is… and I am very short and I am a proud grandmother of Abigail … I put it there because I want the whole world to know!*

Another woman had this to say on being a grandmother, *" I looove it, I think I was born to I t… I just sort of embraced it, you know!"*

Some of the responsibility of being a grandparent is reflected by the statements about the struggle one woman had with her premature grandchild and very ill daughter, who had developed severe eclampsia at twenty eight weeks of gestation*: "I was going to love this baby for the father who wouldn't love her, for the mother who couldn't love and I was going to love her for … uhm, I just wanted her to know that somebody loved her and cared for her."* Her grandchild was delivered prematurely because of the mother's condition (severe eclampsia); this placed enormous stress and responsibility on the new grandmother in this case. However, she later realized the need to change her role, once mother and baby were sufficiently recovered, *"I wanted to do everything that I could, maybe too much. I was too involved but I have learned to back off now."*

In addition to playing the grandparent role, women also share responsibilities as caretakers and caregivers for elderly parents. This was particularly hard for the Hispanic-speaking woman who found the long distances very stressful. Speaking about her mother living in another country and her

responsibilities to her mother reflects emotions other than joy.

> *It hurts to see her and then the distance. I wish that I could be there more to help more … but I help with money for medical care … I don't have need for new clothes all the time and so I just save and send money … it makes me happier, it's quite pricey for medications.*

Some of the women experienced having to care for their own grandmothers and although they deemed this a privilege, it was also perceived as an additional workload.

> *I have a grandma and she has just moved up to Northern Idaho to be with my folks. She is 92 years old and absolutely amazing. I used to do a lot of the care for her but she felt that she would like to live out the rest of her life near her daughter, my mom, so we have relocated her there. She is really my grandma … it has been an adjustment for me.*

Not all the women in the study enjoyed the same experience of grand-parenting. Some of the women defined their grandparent role as one of less involvement and this was reflected in the following exemplar:

> *I have grandchildren, I enjoy being with them but I have to admit, I like being with them on my own terms … I am probably not your typical grandmother that likes to be with them all the time … uh, I am not that type of grandma.*

In this study, two of the women were not grandparents but they expressed keen anticipation at the prospect. Although the grandmother role and "carer role" emerged in this study, none of the women referred to a need to develop a "couples role" with their spouses. According to Friedman (1997:280), each person attains a position in their own society but for each position, a role is required and this role for women is housekeeping, childrearing and then some community responsibility. This assumption may be said to apply to the women in this study as they perceived themselves as homemakers who had reared their children and had fulfilled a function in the communities in which they were placed. In

their study of Mexican-American families, Holtzman and Gilbert (in Condon 2004:136) found that spousal support reduced role conflict and stress.

Condon (2004:135) is of the opinion that role conception is how the individual perceives the role to be. Hardy and Conway (1992:218) state that it may be that role transition is part of the process that not only allows women to move from one role to another in the social context but also allows them to bring about changes in their self-role and as a result, in self-concept. This may explain why the women in this study had a good self-concept (see below).

In addition to role change, the women referred to contentment as central to the midlife experience.

- **Women in midlife experience contentment**

Contrary to common media portrayal, the women in this study reflected on midlife as a period of contentment with what they are and where they are. One of the woman commented, *"I like who I am.*" Northrup (2003:7) calls this "menopausal wisdom", Condon (2004:506) calls it "menopausal zest", and George (2002:83) found that the women in her study had new confidence and reflected on this stage of life as a "new beginning". *Encarta World English Dictionary* (1999:392) defines contentment as "satisfaction or a feeling of calm satisfaction"; *Webster's Collegiate Dictionary of the English Language* (2002:153) defines it as "being satisfied with things as they are". This epitomizes how the women expressed their experience, as demonstrated by the following exemplars:

> *Heavens no, life is good. I like where I am right now and I don't think that I am a raving lunatic or anything like that. I am a lot more placid than I used to be … almost calm. I really like being able to do things for myself now … I am enjoying my life right now. I really like having the time to do the things that I really love.*

My husband and I say it all the time … we love our life, we love our life … we, God is just so good to us … We are looking forward to having time together, we are looking forward to retirement.

Contentment was demonstrated as an indicator of satisfaction with one's life. One participant explained that she felt that she was materialistic, that big and "gorgeous" homes were important to her, but this had changed with age:

But now that I am getting older, I am more content. I am not so much interested in getting a larger home, a more beautiful home. My home would be okay if I could get it decorated the way I would like … so … materialistic I am. But, it doesn't control me and, er, I am getting more content with what I have and accepting that and no matter, I probably would always want more, you know.

George (2002:83) found that women in midlife experience see this as a new phase in life. That, in fact, the "empty nest" syndrome is not as prevalent as the literature might indicate. One woman in particular appeared to have a philosophy of gratitude for and resignation to her life and the circumstances in which she found herself. Being happy with one's situation may be defined as being content.

I try to be happy for things I cannot change. I am always content with what I have … uh, if I have dinner and the dinner is a bowl of rice and meat or tuna, whatever it is, I am grateful that I got it. So, you see, I am always grateful for everything, I always find the positive and try to be grateful.

The same woman returned to this theme several times during the interview and passionately expressed her value of age being blessed with wisdom and contentment:

I want to be older with dignity. I don't want to be having plastic surgeries or putting on an outfit that doesn't suit me or like to dress like a twenty-year-old and look ridiculous. No, no, no, I don't ever want to do that!

In many of the interviews, contentment was linked with spiritual connections and their relationship with

their God. Review of the current literature could not confirm this connection although it is a biblical tenet that “Godliness with contentment is great gain” (1Tim 6:6).

The literature review did not reveal a direct connection between ageing and contentment, although this could possibly be viewed as “generativity” as suggested by the seventh stage of Erikson’ s eight stages of human development (Pilliteri 2003:784). Mercer, Nichols and Doyle (1989:7) point out that there are two major developmental principles, namely the epigenetic and the orthogenetic. It is beyond the scope of this study to discuss these two principles and schools of thought other than to briefly describe them. Epigenetic theoretists, like Erikson and Freud, purport that a plan exists for everything that grows. Orthogenetic theoretists, like Levinson, hold that “wherever development occurs it proceeds from a state of relative globality and lack of differentiation to a state of increasing differentiation” (Werner 1967:126). According to Levinson, Darrow, Klein, Levinson and McKee (1978), as humans become more individual and independent as a result of differentiation with their environment, they are more likely to develop a better self-concept and peace within themselves (Mercer et al 1989:8). Levinson and Levinson’s life structure theory of development postulates that adults go through stages as they develop, however, women tend to link their life stages to their family life cycle and hence, the end of reproductive life becomes somewhat meaningful in a woman’s life. This may provide a sense of accomplishment and, thus, contentment. Most of the women expressed contentment while none expressed feeling fulfilled as a human being although this may well be implied (Levinson & Levinson 1996:47).

In addition, contentment may well be linked to the freedom to be themselves and many of the women in the study described this as independence.

- **Women in midlife experience independence**

George (2002:83), Northrup (2003:77) and Pogrebin (1996:234) describe independence in midlife. Among the reasons for women feeling this way are that the children have left home and having more

time for themselves because of decreased responsibilities. Northrup (2003:97) refers to this independence as "coming home to yourself". Most of the women interviewed enjoyed the opportunity and experience of independence from the childrearing role and expressed the joy of being able to exercise this independence in several ways. Some of the women felt that their sex-life had improved because of the freedom of not having children in the home while others just enjoyed the liberty of doing things just for themselves.

> *The only thing that has really changed is that I feel more free to do my own thing now because I don't have the responsibility of the kids and my grandma anymore. It's like an independence sort of, quite nice really. Life is good. I like where I am right now and I don't think that I am a raving lunatic or anything like that. I am a lot more placid than I used to be, almost calm. I really like being able to do things for myself instead of worrying about school meetings and soccer practice.*

Several of the participants expressed being free to do their own thing as one of the things that was positive about midlife.

> *The part I do like is that I am getting better at not caring about what others think so much, you know, the judgmental part, you know … uhm … oh I don't know the word I want to use … but gradually I'm leading to a more free spirit and I feel like I can do what I truly want to do and be what I truly want to be instead of being concerned about others.*

In addition to feeling independent, the women all reflected on how they felt about and saw themselves.

- **The experience of positive self-image and self-esteem**

Although the women did not see themselves as getting old, they did not appreciate the changes that age had brought, especially with regard to skin and weight. This resulted in a conscious effort to maintain a positive self-image and consequently self-esteem.

I think it's important maybe more … the most important thing is what's on the inside but I still want to look good, I am not ready yet to let go. For my husband, I still want to look attractive to him!

The problem I have with midlife is what the body does at this time. It's really hard because I don't feel like I am really old yet, I know that I am not a young chicken either, but I just don't like what the body does. You know, the drooping, the wrinkles and just what your skin does. I guess I am a little vain … you know, I just don't like that part at all!

While paying attention to appearance and grooming, there was the connotation that the women value what could be described as inner beauty. The woman who had undergone liposuction added:

I really do believe that it is important, you know, who you are rather than what you look like. I think the most important thing is really the inside beauty and not the outside and I am working on that also.

Currently, self-help books and talk shows abound with the concept that the above exemplar states; Northrup (2003), Condon (2004), Legato (2002), Warga (1999), Pogrebin (1996) and Shaevitz (1999) are some examples of current writings available on-line and at many local bookstores. All these authors focus on the importance of knowing who you are as a woman and accepting who you are during midlife specifically. Several of the women interviewed mentioned some of the books listed as being helpful in this transition. Two of the authors have been interviewed on popular talk shows such as the Oprah Winfrey Show, which is predominantly watched by women.

Olshansky (2000:77) asserts that the concept of self-esteem is essential to well-being and health and further that "women who have a healthy sense of self will be healthier in an holistic way". Northrup (2003:54) holds that for self-esteem to develop in women, relationships are essential as they influence women's sense of well-being. Not only are the relationships with one's spouse, children and family pivotal to this process but also a relationship with one's self is essential. Northrup (2003 55) refers to this as "coming home to oneself."

The changes that the women expressed also included fears and concerns about HRT. The dominant concern was the fear of cancer, particularly of the breast. This was consistent in all the interviews.

- **Some fears experienced by women in midlife**

During the interviews fears common to all the women emerged. The fear of what is happening in the pharmaceutical community pertaining to HRT was the most commonly expressed concern. In addition, the women expressed anxiety about cancer, particularly cancer of the breast. This resulted in them undertaking preventive screening such as mammograms. This would be an area of concern because the American Heart Association (in Condon 2004:244) indicates that the primary killer of women in this age group is cardiac disease. Only two of the women had undertaken any prophylactic cardiac screening in spite of an awareness of the value of such screening. Only one of the women used HRT (see chapter 2 for a discussion on HRT). All the women mentioned fears about HRT, specifically the possibility of cancer of the breast.

> *The doctor asked me if I had any symptoms that maybe he could put me on the estrogen pill, but I refused, because there is a lot of cancer in my family and they say it is best not to.*

It is difficult to know whether these fears were fuelled by the extensive negative press coverage that HRT has received in the USA.

- **Women in midlife experience spiritual growth and awareness**

Spirituality and spiritual growth emerged in all the interviews in spite of diverse religious backgrounds. Religious denomination or affiliation was not asked on the questionnaire, but spiritual issues were evident in all the interviews. Most of the women were from conservative Bible believing churches; one was a devout Catholic, and three were members of the Church of Jesus Christ and Latter-Day Saints more commonly known as Mormons. The latter were purposively asked to participate because this

faith is highly represented in the population of Idaho and the northwest areas of the USA. The women were not asked specifically about spiritual growth and changes and the responses emerged as a sub-theme throughout all the interviews. Many of the women in the study commented that as they got older it meant that they had more time to reflect on God and the things of their faith. Pogrebin (1996:263) is of the opinion that women become more responsive spiritually as they age, and links spirituality and solitude as new pleasures that are part of midlife when children have left the home. This was dominant in all the interviews and among the Mormon women, in particular. Crises and problems had a profound effect on the women's spiritual growth. One woman referred to the death of her grandchild and its effect and another spoke about the premature birth of her granddaughter.

> *And through that experience, though I was walking with the Lord but I had kinda drifted off, but that has drawn me back again.*

> *I'm thinking of the situation every day. You just go and do what needs to be done. I certainly pray a lot more; I've drawn closer to God. I'm surprised He doesn't keep me in that sort of stressful situation all the time because that's really when I am on my knees where I should be!*

More time to exercise spiritual things like prayer and service was seen as important. Women of the Mormon faith placed a lot of emphasis on having time to study the faith and to serve their church family. This denomination runs very structured education classes on their beliefs and traditions. Although the women have no public role in the church, they have the major responsibility of being the knowledge providers for their children therefore education in doctrinal issues is of primary importance. Thus, the time to develop and commit to spiritual behaviour resulted in an awareness that God was in control and leading in their lives.

- **Women in midlife experience a sense of God's leading**

Carson (1989:27) defines spirituality as "the core of one's being; a sense of personhood; what one is and what one is becoming". According to Matteson (2001:118), spirituality or that sense of inner being becomes the basis for decisions in the lives of women. This impacts on the decisions that they may make with regard to health and healthcare opportunities.

The women in this study expressed a sense of acceptance that "God is in control". This was not specific to their religious affiliation but rather a personal belief that God was allowing things into their lives for a purpose and reason.

> *You know there are no answers, really no answers and that is what makes it so hard because you don't have answers but that's where your faith has to come in and God has His reasons and one day hopefully we will have an answer to that.*

Most of the women referred to spiritual growth as one ages. This was also portrayed as part of the changes that occurred with maturity.

> *Spiritual really … I am increasing my walk with the Lord and I think that helps me tremendously. I think it's most important above everything, what's on the inside.*

In addition to having a relationship with God, the women were very aware of their own and their families' mortality and this was reflected in different ways.

- **Women in midlife experience thoughts of mortality**

Webster's Collegiate Dictionary of the English Language (2002:472) defines mortality as "being subject to death". Direct reference to death and dying surfaced in the second interview, with regard to the prospect of death and deciding on whether to be buried or cremated.

Death I don't actually fear it … I feel more comfortable about death and that's I think due to my walk with the Lord and my spiritual growth. I am really not afraid of death. I would want to find it. The biggest thing I have is whether I want to be buried or cremated! I don't want to be cold.

Other mortality issues revolved around ageing parents and this concerned the majority of the women interviewed. Less direct inference was evidenced through the interviews with comments such as *"before you know it they will be gone"* and *" I want to do that before my parents die."*

Death and mortality issues did not appear to create fear but rather resignation and once again the aspect of God being in control of such an event:

I am concerned about my mortality. Yes, definitely, yeah … that time is getting by … um ... how to say? I think about it but not in a fearful way, it's just that I want to see my granddaughter but I feel that if it is my time then, there's not much you can do about it and then I just have to live life to the fullest and that's when I become aware of getting older. So, yeah, I am aware of my mortality.

I know, so I think that when you are young, your hormones are everywhere, you worry about guys but now, even though I am aware of my own mortality, I know that things are going to happen no matter what. There is no sense in rushing into anything, I know, so I am calm.

In addition to resignation about mortality, several women expressed concern at leaving behind spouses and younger children. These concerns centred on the care that they needed more than a loss of physical presence.

I have been thinking, have I got cancer, am I going to die? You know, I can't die because my granddaughter is only four and she needs me. You know, I don't want to leave my husband and son on their own. They would eat Doritos and Pepsi for the rest of their lives!

The researcher did not find the prospect of death and dying is not an issue of midlife transition reflected in the literature. Condon (2004:512), George (2002:77) and Gingrich and Fogel (2003:181-189) do not identify mortality as an area for concern although George (2002:83) talks about women being in "a new phase of life".

While the experience of the physical and psychosocial changes of midlife were identified and examined, the women in the study also managed these same changes in two ways: developing and using the physician relationship, and the use of self-care strategies.

3.4.2 How women in midlife manage the process of midlife change and transition

In spite of the changes that the women experienced as they transitioned through midlife, there is a perception that the changes of the process are normal and should therefore be managed as such. Lifespan development theory commonly asserts a normative sequence to the process of emerging from one lifespan event to another (Levinson et al 1978:50). Erikson (1958), Maslow (1971) and Havighurst (1972) identify subjective stages through which all humans travel, however, no allowance was made for gender differences nor for contemporary lifestyle changes. A methodological problem in many of these theories would be the fact that their research samples were composed of only men and therefore the assumption was made that women as they transitioned from one stage of life to another would behave in the same manner as their male counterparts. Levinson (1977), a theorist who was more interested in ageing, made little reference to possible sex or gender differences in his writings; but men and women were included in his research sample. Levinson and Levinson (1996:187) found that development continues throughout adult life and women experience similar life cycles to their male counterparts. However, they experience the transition of life cycles as bound to their own personal family cycles. The women in this study endorsed this assumption. Levinson et al (1978:50) identify a four-stage adult development process in which two of the stages are a stable period when one is building a career and family structure (early adulthood stage) and a transitional period when one

moves from one stage to another. Middle adulthood would be an example of transition. This transition may take several years and requires introspection and reflection (Grambs 1989:48).

According to developmental theory, in addition to change, learning occurs concurrently with developmental life stages. Each stage allows one to transform from the previous one although the rate at which this occurs will differ with each stage (Hancock & Mandle 2002:727). In her model of health promotive behaviour, Palank (1991:815) states that individuals themselves will make the difference to health promotion when they make the effort to feel better physically, psychologically, socially and spiritually. Levine (in Parker 2001:107) discusses the change process in her conservation model as adaptation. Adaptation is the process of change, the process whereby people maintain integrity within the realities of their own environment. According to Levine (1991:3), the person is a holistic being and individuals will respond to every alteration of their life pattern (as is the case in this study). The Levine model is criticized for only being useful for critical care settings. According to Parker (2001:105), Levine sought to modify the model to include community-based care.

3.4.2.1 Negative and positive relationships with health care providers

The women indicated that their relationships with health care providers were exclusively with physicians and the majority of the experiences were of a negative nature. The women stated that the physicians did not listen or communicate effectively, and could be secretive and dismissive. Positive experiences were that the physicians had superior knowledge and knew what needed to be done. Other health care providers mentioned were pharmacists, chiropractors and physical therapists.

- **The physician's role in the midlife experience**

The women all expressed some sort of professional relationship with their health care professional. Most of them used the physician as their primary care provider. Nurses appeared to be invisible in the interviews as not one woman mentioned nurses in any context at all (see chapter 6 for discussion). Most of the women expressed dissatisfaction with their relationship with their physician and many felt that the doctor's gender was an influencing factor. The women, for the most part, chose a female physician because they were of the opinion that a woman would be more likely to understand their experience. In all cases, this had been a negative experience for the women who found that the physician's gender did not influence or facilitate more empathetic care. Only one of the women had a positive experience of a physician and in this case the doctor was a male. Bond and Bywaters (1999:857) found that physicians fail to behave proactively and responsively with regard to women and an informed decision on HRT. Furthermore, physicians fail to make prescribing practices patient-centred, which in this case were women in midlife.

However, the women also commented positively on the role of physicians as described below.

- **The positive role of physicians in women's midlife experiences**

On the positive side, the women stated that they felt that the physicians would never knowingly harm them and had knowledge and expertise that enabled them to make enlightened decisions of behalf of their clients.

> *I don't look forward to the visit although I feel it is important and I don't look forward to going and yet I, yet I am glad that I do because I have a lot of confidence in my gynecologist and so it has not been a stressful thing. I did speak to my gynaecologist and he feels very strongly that I should stay on HRT… he just feels that it is good and so after speaking with him I have a lot of confidence with him and he knows. So, at this point I chose to stay on it!*

This woman had read the Food and Drug Administration (FDA) warnings on long-term HRT, but chose to take her physician's advice in spite of what she knew was current research thinking.

The women in the study who felt that the physician's role was not helpful overshadowed the physician's positive role. Time constraints and poor communication skills were identified as a negative experience of a physician's visit. The average time spent at a physician's visit in the USA is about 14 to 15 minutes (Gross, Zynanski, Borawski, Cebul & Stange 1998:43). This reflects an increase in the time that the average physician spends with patients. However, the satisfaction index has gradually decreased since the 1990s. This may be because more technical procedures are done now and there is little actual communication between client and physician.

- **Negative impact of physicians' care**

The negative experiences of the women included time, communication and indifference. In several instances, the women felt that the physicians were always rushed and therefore did not listen to what they were saying.

> *My doctor that I have been seeing since 1989 just seemed to be very lackadaisical and she's female so that sort of put me at ease, you know. Well I thought, she's a woman, she has a uterus, you know, she knows a lot. But I just felt that her practice was growing too large to take care of me and I told her. I made an appointment with her and told her. I said, I am going to take my records and see another doctor, you are just too busy for me. She got quite offended by that!*

With regard to cardiac screening tests and the speed with which the visit was conducted and whether she would go back to the same doctor, one woman said:

> *They do that, yep, they do that. But you know, I felt kinda "slam, bam, thank you ma'am". Not to her! I don't know who I am going back to when I need to. For many years I was, you know, you need to go to an internal medicine doctor and so I go to one and then … then they are not any more helpful*

than the other one. I don't know. That's primary health. I don't know what your health insurance is like, but with us they treat us like cattle!

Schultz (2001:16) emphasizes that men and women use language differently. Males use language to promote their own power and sense of control while women use language in an inclusive manner. Schultz goes on to say that the male mode of communication is the norm in medical language, the physician/patient relationship is always hierarchical and the language that the doctor uses may be disrespectful of the patient's own autonomy. This may account for the women feeling that the physicians did not listen. This perception is irrespective of the gender of the physician. Schultz (2001:16) highlights the dilemma of physicians embracing the theory of the right to information, but their clinical practices and communication styles often use language that contradicts their theoretical statements of intent. Furthermore, much of the actual language used by physicians conveys disrespect and this is particularly important when the client is a woman. Hall and Roter (1998:39) maintain that gender does make a difference, however, and that female physicians engage in a more egalitarian approach to the patient/physician relationship.

In a Yale University study, Sarrel (2003:9) found that one in five women was dissatisfied with the care and information received from the healthcare professional, specifically with regard to the benefits and risks associated with HRT. In addition, the time spent with the women did not match their expectations. The women also felt that the physicians did not communicate honestly and truthfully, which led to feelings of mistrust. Groszkruger (2004) examined the correlation between malpractice and the length of time spent with patients and found that the patient/physician relationship is best served when the physician pays attention to communication, both verbal and non-verbal.

My original doctor, who ordered the sonogram, never mentioned it to me. He never mentioned it to me. So, ah, he should have told me. It was never discussed with me. I would have remembered had it been discussed with me!

In addition to using their physicians to maintain a healthy menopause, the women also employed a variety of self-care strategies in order to manage the process and maintain a healthy lifestyle.

3.4.2.2 The need to utilize self-care strategies to maintain a healthy lifestyle

The women managed this process in diverse ways that included a professional relationship with health care providers and the use of numerous self-care strategies. Matteson (2001:161) describes self-care strategies as "those strategies that a woman provides for health care needs". Fishbein and Bash (1997:23) define self-care as women "being active participants in their personal health care". Although all the women in the study engaged in some activities that could be deemed self-care, none of them reflected this in the health questionnaire. It appeared that they did not categorize these strategies as self-care.

Matteson (2001:190) points out that before one can contemplate self-care strategies, it is important to establish what it is that women perceive or believe menopause to be. Not only is it important to explore what they believe, it is vital to explore what women perceive as impacting on them specifically. Self-care strategy choices may have a positive effect on the menopausal transition (Matteson 2001:190). Milio (1976:435) asserts that health-promoting behaviours are related to habits of choice and these are determined by the resources available and by personal habits. Milio (1976:436) states further that the individual needs to make a personal investment to change health behaviour. Palank (1991:815) emphasizes that the individual makes the difference in health promotion and strategies should be included in health education programmes that facilitate the process of self-investment in health. According to the WHO (1984:34) health promotion should include a healthy lifestyle, a supportive environment and reorientation of the healthcare services and public policy. Health promotion efforts should encompass family, individual, community, environmental and societal wellness (Pender 1996:8). There is no consensus on the definition of health promotion, which is not easy to define.

According to Pender (1996:7), health promotion is distinctive in its motivation to actively increase well-being and harness whatever health potential humans have. Health protection models, such as the health belief model, actively strive to avoid illness (Pender 1996: 7). This clearly delineates the differences between the health belief model and Pender's health promotion model. The theoretical underpinning of Pender's health promotion model includes expectancy-value theory, social learning theory and a nurse perspective of holistic human functioning (Pender 1996:53). Pender (1996:53) holds that people seek to create conditions optimum to their health potential and are able to reflect and therefore assess their own competencies. Furthermore, people will regulate their own health behavior and individuals will attempt to achieve balance between change and stability. The role of health professionals in this model is that they form part of the interpersonal environment. Pender (1996:97) describes self-care as "activities initiated or performed by an individual, family or community to achieve, maintain or promote maximum health".

In this study, the women all used some form of self-care; diverse strategies included exercise regimens, dietary choices, supplementation of herbal and natural products and the use of preventive and promotive strategies. Informal strategies such as walking, swimming and weights were the predominant exercise regimens used by the women concerned. Not having time was the major reason given for not joining a structured or formal programme and the majority of the women did not enjoy the environment of the actual venues associated with fitness programmes.

- **Physical exercise**

Exercise is recommended for women as they age for several reasons, namely the prevention of osteoporosis, cardio protective health and fitness, and the positive impact of exercise on mental and emotional health. Edelman and Mandle (2002:328) and Reichler (1998:128) found a positive correlation between weight-bearing exercise and the prevention of osteoporosis. Condon (2004:239), Edelman and Mandle (2002:323) and Legato (2002:111) underline the value of walking fitness in cardio protection. Reichler (1998:194) states that exercise may also be therapeutic in the management

of stress-related disorders. While exercise is recommended for its long-term health benefits, the primary reason given by the women in this study was that it was essential to the maintenance of weight or associated weight loss.

> *I work out about three times per week. I do 30 minutes of stepping and 15-20 minutes of weight lifting.*

> *I try to keep my weight in check and maybe that's not a very healthy thing to do because I don't think I do it very healthily. Right now I'm sort of doing the low carb thing.*

> *Yep, I am a member of the Mountain Club and they have a very nice track pool and I swim year round. I find that swimming is not so hard on my joints; not so much, you know, like one does when one is jogging. The impact is real hard on the knees. I also do some walking, weather permitting.*

In addition, preventive and promotive screening was employed, including cardiac profile screening, mammography, Papiniculae (Pap) smears and bone density assessment.

- **Complementary and promotive strategies**

Pender (1996:8) states that the multidimensional nature of health promotion is not only affected by the individual. The community, the environment and the society in which they live also impact on it. Moreover, health promotion strategies are complex and health promotion by the individual not only improves personal decision-making but also makes a difference in health practices (Pender 1996:8). The women in the study used various health promotive interventions, including mammograms, Pap smears, bone density screening and blood profiles for cholesterol and cardiac lipids. All of these were

done outside of their physician's office at community screening drives and the costs covered by the women. It was clear that the women had taken ownership of these preventive decisions.

> *I have all the checks: Pap, mammogram, but no cholesterol. Mind you, I haven't had cardiac bloods done either. Well, the doctor said if I'm not having any pain she didn't need to do anything. She knows my history* [history of early age cardiac deaths in the family] *but I still haven't had a cardiac workup so I am not overconfident with physicians and their care. I will have it checked, there's lots of places that do so … it's not a problem.*

> *I haven't seen a doctor in three years but I do the screening things because I work at St Luke's and there are a lot of projects offered and so I have had the usual mammogram and cardiac profiles. Actually, they told me that my cholesterol levels were in the, how did they say it, upper limit of normal and so I should be more careful I suppose? I will have it rechecked again but otherwise everything is fine. I try to be good about the screening that is offered because of where I work … I need to set an example!*

The women also mentioned alternative practitioners like chiropractors, masseuses and magnetic imagery. *"I see a chiropractor from time to time, mainly for infrequent flare-ups from an old back injury."* For the most part, alternative services are treated as out-of-pocket expenses. In addition to participating in complementary practices, the women also made use of supplements and some natural products.

- **Health care supplements**

The majority of the women in the study admitted to using supplements, including multivitamins, herbal and mineral supplements such as magnesium and calcium. The use of these supplements was sporadic but always as a result of personal choice. Supplements are predominantly marketed to women because they are seen as the member of the household who determines healthcare purchases. The difficulty with these products is that, to a large degree, they are marketed for their

curative rather than their preventive value (Olshansky 2000:139). One of the women was using a natural progesterone product in order to avoid the use of HRT. Lee (1996:143) recommends the use of natural progesterone products as opposed to HRT for improved adrenal and thyroid function, enhanced sleep patterns, the prevention of osteoporosis, cardio protection and memory enhancement. According to one of the women, "*The doctor has got me on a natural progesterone cream, a topical cream that she has the pharmacy mix up for me. I think it's like 15mg.*" The participant perceived that there had been an improvement since she had commenced the cream. Only one of the women was using essential fatty acids (EFA's), sold as Omega 3 and 6s that are essential for cardio protection (Murray 1996:250). On no occasion had the women been encouraged by their physicians to pursue these options. The woman who was taking EFA capsules had their use suggested by her dietician because of her high cholesterol profile. "*Olive oil is important in the Jenny Craig diet and I am taking the Omega 3 or is it 6, capsules each day?"*

It appeared that there was random use of supplements and for many of the women the motivation for using these was an outcome of having read about the benefits on the Internet or in a magazine or book. Supplements included magnesium, calcium and multivitamins. These were purchased from a variety of sources and no brand loyalty emerged from the interviews.

> *Magnesium, I am not sure why I am taking it but I think it might be for PMS, I don't know or maybe for weight loss. Not sure why I am taking it. I must have read it somewhere. I take it regularly and also a multivitamin. Everything else I can't remember to take. That might be because I am going through the change. I don't know. I am doing very well, these last two weeks I have remembered to take them every day but I just wish I could remember why I take the magnesium. I probably read an article, which said that we don't get enough magnesium and so I thought, whatever it was, it was something that I felt like something that I needed. So yeah, I didn't contact the doctor, heaven forbid!*

Family advice played a role in the use of supplements too.

I take calcium because last year my daughter made me do a bone density and it said that I was losing a little and I don't eat dairy that much, so they suggested I take calcium. Yeah, but I take them often or regularly because I hear different stories about calcium, so I don't know! I read that if you put one of those calcium pills into vinegar and it dissolves, it isn't good because the stomach is acidic and so it won't help as the calcium is absorbed. But I try to eat right.

The most commonly used strategy for self-care was the use of diet and all the women referred to this.

- **Diet regimens**

All the women made mention of some sort of dietary programme, from weight-reducing diets such as prescribed meal plans to the Atkins and low carbohydrate diets. Cultural dietary items were also included and this was specific to the Hispanic women in the group. Current research indicates the importance and relevance of following a diet that is helpful to hormonal balance in midlife (Condon 2004:512; Shearer 2003:32). Northrup (2003:206) indicates that it is absolutely essential to maintain one's blood sugar eicosanoids and estrogen levels through a dietary plan and suggests frequent small meals with small portions of protein at each meal and low grains. Furthermore, eating the healthy fats each day and protecting oneself with antioxidants also contribute to hormonal balance. Hart and Grossman (2001), Legato and Colman (2000) and Shearer (2003) stress the importance of diet during the midlife years. All the women in the study mentioned that watching their diets was an important factor although very few mentioned diet in relation to health benefits. The predominant thought pertaining to diet was that it related to weight loss and maintenance.

I am on Jenny Craig. I am trying! When you reach your goal, you go on to half their food and half regular and so I am watching what I eat. Right now I am on their food and so I am hoping that I get to half really quick! I needed to get the weight off and the easiest way to do that was with programmed meals. Well, I don't know what your diet would be for low cholesterol but, believe me, you are not eating enough for anything. It's not high meat or high vegetable or high fat. I am very regular so it must be okay I guess!"

Changes in food preference and dietary habits also emerged from the interviews.

> *So I try to make healthy choices and the older I get, the more important it is for me. I have always been fairly active and I do try to do lots of vegetables and fruit. Um, I never until I was older, never did sweets much. I was always a salad person and vegetable eater even as a child, until very recently. That's the one thing I have noticed is that I never did like sweets and now I just love them!*

According to Lee (1996:136), a craving for sweets and sweet things is symptomatic of an overload of estrogen, mainly because of HRT, and this contributes to weight gain and adrenal burnout.

3.4.3 Themes

The researcher followed Tesch's (1990:142-145) model and two dominant themes emerged when the data had been collapsed: (1) how the women experienced the process of transition to midlife and (2) how the women managed the process of change. These themes were recurrent throughout all the interviews and thus it was concluded that saturation had been reached.

Midlife has been and is currently a topic of heated debate, not only in scientific research circles but also in the consumer market. Two divergent philosophies have emerged as a result. According to the disease profile view, "menopause is a socially constructed, age-related hormone deficiency disease that produces symptoms and increases the risk of illness" (Condon 2004:502). In terms of the sociobiological view, it is not natural for the female species to die shortly after the completion of reproductive life since anthropological research indicates that it is natural for females to live decades beyond menopause (Blaffer Hrdy 1999:42). Philosophically, midlife can be viewed negatively as life half done (over) or positively as life only half lived. Proponents of the negative view regard midlife and menopause as an abnormal outcome of women living beyond reproductive years.

3.4.3.1 The process of normal change and transition

Change was expressed in many of the interviews and the women viewed it as natural change, expected change and normal change. The women found the change normal and part of life. For example, "*Nothing seems to have changed*. *The kids have gone but other than that, nothing has changed."* The women in this study indicated that for them change was linked to what they could see and feel rather than a political process. Change was used interchangeably as a negative and positive term among the women. Positively applied, change was seen as normal and what was supposed to happen *"nothing has changed*" and *"things seem the same as when I was twenty years old". Webster*'s *Collegiate Dictionary of the English Language* (2002:118) defines change as "make a difference/alter". Things had altered in many of the women's lives, in both the physical and psychosocial contexts. Negative change reflected the physical things that occurred and over which they had little or no control, such as skin changes, weight and body changes and the change in energy levels.

3.4.3.2 The way in which women in midlife managed the process of midlife change and transition

Managing the process of midlife changes involved several strategies. Relationships with physicians were pursued and although for the most part these were of a negative nature, the women did feel empowered to make choices about whether or not to maintain this relationship. In fact, some of them elected to explore other options. Screening, exercise and dietary regimens were also followed. All the women in the study practised dietary restraints to maintain weight maintenance and loss. A variety of self-regulatory exercises were employed to ensure fitness and maintain adequate musculature. Supplements and herbs were used by many of the women in the study even though no scientific rationale could be given for choice and usage. Positive attitudes reflected the view that this period of change was normal and an opportunity for new beginnings. George (2002:81) found that menopausal women perceive this time as an end of an era and the start of a new life phase.

3.5 OMISSIONS

3.5.1 Support from girlfriends

None of the women interviewed mentioned “girlfriend talk”. It was not clear from the interviews whether this was a reality or whether the women just overlooked their own friends as a support system. Condon (2004:512) maintains that women manage midlife better because of their expanded support systems and roles as opposed to men who remain insular, especially as they age. Only two of the women referred to their own mothers and this concurs with George’s (2002:82) findings.

3.5.2 Hormone replacement therapy (HRT)

The majority of the women in the study were not using HRT. Sarrel (2003:414) found that fewer than 25% of women in the USA make use of HRT. One woman continued to use HRT in spite of being aware of the risks involved. She considered that her physician knew what was best for her and therefore continued using her HRT in spite of associated family risk factors. The FDA (The Associated Press 2004:3) recommends the lowest dosage for the shortest time. All the women mentioned a fear of the side-effects of HRT resulting from what they had read in the media. The predominant fear was cancer of the breast.

3.5.3 The classic picture was not evident

The classic picture of hot flushes, emotional dysphoria and severe depression and anxiety was not evident in this study. George (2002:80) and Gingrich and Fogel (2003:181) found that rather than being a biological, pathological condition, menopause was a normal developmental process. Pogrebin (1996:192) states that women in the USA have a rather privileged way of traversing menopause and

midlife. She maintains that given the life events of women in many third-world countries, midlife menopause is a “non event.”

3.6 CONCLUSION

This chapter discussed the participants’ experiences of midlife transition with reference to the literature and in this manner, the experiences were verified. It became clear that midlife is perceived as a normal process of development and transition. The women are also engaged in certain activities that balance this transition and allow them to adapt.

Chapter 4 describes the development of a health promotion model for the support of women in midlife change and transition.