CHANGING LIVES: A PERSONAL CONSTRUCT APPROACH TO MENOPAUSE

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by

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Abstract

This thesis argues the need for an exploration of the meanings, and pathways to reconstruction, of women anticipating or experiencing menopause, and that a personal construct approach can provide a creative context for meeting this need. Very few psychologically based interventions for menopausal women have been reported in the menopausal literature.

I describe my development of a personal construct model of menopause, consisting of two major meanings of menopause, and five patterns of construing, including a pattern for intervention. I also describe two studies. Study 1 was an exploration of the meanings that women used in construing their expectation and experience of menopause. I identify the themes in the women’s construing. The most frequently occurring were awareness of physical or psychological change, expressions of distressing emotion, and an inability to predict what was happening. Women also spoke of a lack of opportunities for discussion, and their difficulty in decision-making in this context. These themes made clear the need for an intervention.

Study 2 consisted of the development and evaluation of a three-session Menopause Workshop, designed to facilitate women’s reconstruing of themselves in relation to menopausal changes. The overall aims of this study were: (1) to reduce the women’s anxiety and feelings of helplessness in relation to menopause, and (2) to increase the women’s feelings of control, hope and positive feelings in relation to menopause. I conducted an outcome study using a repeated measures, contrast group design. I used content analysis scales to assess the level of emotion reflected in women’s construing about menopause at three data collection times: pre-workshop, post-workshop, and after five months. At the first data collection the women were screened using a measure of distress, and women with scores above the norm were assigned to Sample A (Above average), and women with scores within the normal
range were assigned to Sample B (Normal). A further Contrast Sample (Sample C) was formed of women who took part only in data collections. For the women in Sample A there was a statistically significant long term decrease in anxiety \((p = .01)\), and a long-term decrease in feelings of helplessness that approached significance \((p = .26)\). Although there was a significant improvement in the positive emotions after the workshop, this was not sustained after five months. In an unexpected result, the results for the women in Sample B also showed a statistically significant long-term decrease in anxiety and feelings of helplessness \((p = .01)\). Scores for the Contrast Sample showed no significant difference over time. Aim 1 was met: the women’s meanings of menopause showed a long-term reduction in feelings of anxiety and helplessness after the very brief personal construct workshop. Aim 2, however, was met in the short term, but not in the longer term.

I illustrate these results with case studies, and descriptions of the processes of the workshops. I reflect upon the implications of the findings, comment on the limitations of this research, suggest revision of the personal construct model of menopause, and provide directions for future research. The results of these studies provide further evidence that a personal construct approach can play a convincing role in meeting the growing need for effective provision of time-limited psychological services.
CHAPTER 1

INTRODUCTION TO CHANGING LIVES: A RESEARCH PROJECT
EXPLORING MEANINGS AND RECONSTRUCTIONS OF MENOPAUSE
1.1 Statement of Thesis

This thesis argues that there is a great need for an exploration of the meanings, and pathways to reconstruction, of women anticipating or experiencing menopause, and that a personal construct approach can provide a creative context for meeting this need. The research on which the thesis is based was undertaken using a personal construct approach, and comprised two studies. Study 1 was an exploration of the meanings that women use in construing their expectation and experience of menopause, followed by the development of a personal construct model of menopause. Study 2 consisted of the development and evaluation of a Menopause Workshop, designed to facilitate women’s reconstruing of themselves in relation to menopausal changes. The overall purpose of this work is to broaden and strengthen psychological research on menopause by the addition of a personal construct perspective.

1.2 The Challenges of the Change

The ‘Change of Life’ is the focus of this research. This evocative phrase is used to describe a change that every woman of sufficient age must experience. Yet the common name crystallises and preserves a meaning that is at odds with current expectations. Perhaps the term ‘the change of life’ is not used quite so often now, but the word ‘menopause’ itself still trails overtones of significant change. In this society, at this time, however, working women in particular feel obliged to make this transition with as little fuss as possible. While for some women, menopause affects them very little, for others it does indeed represent a change of life, and for these women the current context may be quite difficult.

Kelly (1955/1991a) painted extraordinarily graphic pictures of a person facing the challenges of change. At one time it sounds like a portrayal of someone in a storm, at another like someone standing on a volcano. He said: “constructs enable a person to hear recurrent themes in the onrushing sound and fury of life. They remain relatively
serene and secure while the events above which they rise rumble and churn in continuous turmoil. Yet constructs themselves undergo change. And it is in the transitions from theme to theme that most of life’s puzzling problems arise” (Kelly, 1955/1991a). This understanding that the events in life may lead to a process of transition and reconstruction, underpins this exploration of the experience of menopausal women.

In the last two years the topic of menopause has become a staple of the popular media. Scarcely a month goes by without the latest release of controversial data, receiving headlines in the press and being debated on television and radio. According to the Nexis database (Nexis, 2003), the New York Times and The Times of London included menopause in headlines or the first paragraph of articles, 74 and 57 times respectively, in the past two years, an average of two to three citations per month. The figure for The Australian newspaper was 27 citations, an average of once a month (Nexis, 2003).

The positive aspect of this is that menopause and menopausal treatments are the subject of large-scale studies being carried out in many countries, and the reported findings should improve the quality of care that women are given. It must be noted, however, that large scale studies in the United States and Britain have recently been halted, in the light of findings indicating women in the studies taking hormone replacement therapy were at increased risk of breast cancer (NAMS Advisory Panel on Postmenopausal Hormone Therapy, 2003; Vickers, Meade, & Darbyshire, 2003). On the other hand, publicity in the general community about menopause treatments has created a climate in which women are now facing the changes of menopause, and the accompanying health-related decision-making, in the face of conflicting information.

In the last two years we have witnessed graphic examples of what I have called the menopausal paradox, when too much information is just not enough (Foster &
Viney, 2000). Women in industrialised societies are in a paradoxical position. In a study of women in Western Europe, it was found that women mainly acquire information about hormone replacement therapy through the mass media (Oddens, Boulet, Lehert, & Visser, 1994). Publicity is often given in the media, sometimes dramatically, to conflicting information about menopause, but self-identification as menopausal is still inhibited by taboos and fears, and there are few opportunities for women to develop their own meanings of menopause. Decision-making is hard in this context of confusion, and anxiety can be the result (Oddens et al., 1994).

In this context, women may find that their construct systems of already proven effectiveness are not adequate for prediction during the physical changes of menopause. As Viney (1990) observed, in relation to illness, “people develop their constructs by interpreting their own past experiences” (p 120). In the case of women entering menopausal transition this may not be possible. Opportunities for reflection and elaboration are important in providing a suitable context for revision and the creative process that leads to reconstruction. While, as Dalton (1993) comments, “the notion that there are always alternative constructions to choose among when dealing with the world suggests the freedom we all have to change” (p 116), much depends on having the opportunity to develop those alternatives.

It is evident that this may be a particular challenge for menopausal women in paid employment. Menopausal changes, like other changes relating to women’s reproductive status, may have an impact on women’s well-being, but must be accommodated more or less invisibly within their working lives. Expectations about the ‘normality’ of these changes may leave women who experience difficulties feeling they have to hide their perceived failure, particularly in the workplace, often leaving each woman feeling she must face the changes alone. This may be particularly difficult for women managers. Hard won progress up the promotion ladder could be
jeopardised if a woman were not seen to be completely in control of all aspects of her life.

There is a strong emphasis on troublesome, or dangerous, symptoms in the menopausal literature (Calvares & Bryan, 2003; Hom, Chan, Yip, Chan, & Sham, 2003; Hulka & Moorman, 2001; La Vecchia, Brinton, & McTiernan, 2001; Maartens, Knottnerus, & Pop, 2002; Paganini-Hill, 2001), as well as a continuing debate in the media about the dangerousness of various courses of action that women might consider at the time of menopause. Yet interventions reported in the literature are predominantly medical (La Vecchia et al., 2001; Leung, Haines, & Chung, 2001; Lokkegaard, 2002; Marttunen, Hietanen, Pyrhonen, Tiitinen, & Ylikorkala, 2001; Sirtori, 2001), including some assessing complementary therapies (Sirtori, 2001). Psychologically-based interventions for menopausal women are rarely reported, with the exception of some psycho-educational programs (Robinson & Stirtzinger, 1997). Few researchers have designed interventions and evaluative studies that focus on women’s unique meanings of menopause. Similarly, few attempt to assess, and alleviate, the psychological distress that women might experience in this ever-changing context of alarming information.

1.3 The Research Strategy

This research enlisted the cooperation of women in sharing their unique meanings, anticipating or experiencing menopause. The research strategy comprised two studies, in which a total of 87 women took part. Study 1 consisted of individual and group in-depth interviews with 74 women. Study 2 consisted of the development and evaluation of a Menopause Workshop. Fifty-four women continued from Study 1 to take part in Study 2. The women who took part in the workshops completed three data collection processes, pre- and post-workshop, and after five months. A contrast group of women took part only in data collection processes.
1.4 The Structure of this Report

Following this introduction to the thesis in Chapter 1, in Chapter 2 I discuss conceptualisations of menopause. I identify four models of menopause in the menopausal literature. These are the medical, biologically-based model, currently the most powerful model in industrialised societies; the sociocultural model, which attempts to identify the role played by cultural context, social role, or lifestage in women's experience of menopause; the feminist model, which includes multiple meanings of menopause, and focuses on empowering women, either by an emphasis on women’s individual experience, or by reframing the discourse about menopause to focus on whole women rather than on their symptoms; and the ‘green’ or natural life model, which has developed in opposition to the medical model, and is based on a belief about what is natural and its importance for health and well-being. I then outline developmental and abnormal theories of menopause. This includes a discussion of the psychology of women, and the contributions of relevant women psychologists, followed by a brief discussion of popular representations of menopausal women. The chapter concludes with a summary of current conceptualisations of menopause.

Chapter 3 presents a personal construct approach to change. In it I discuss the centrality of concepts of change in personal construct psychology, outlining the philosophical assumption of constructive alternativism (Kelly, 1955/1991a), Kelly’s (1955/1991a) Fundamental Postulate and Corollaries, and cycles of construction and change. This account is followed by a brief description of personal construct theory in relation to transition and emotion, transitive diagnosis and responses to change (Kelly, 1955/1991a, 1955/1991b).

Chapter 4 describes the development of a personal construct model of menopause. I provide the context for the model, and then discuss menopause from a personal construct perspective, focusing on prediction and invalidation, gender and
core role construing, emotion and the need for change, the cycles of construction, and
the dimensions of transition. In the final section of the chapter I present a personal
construct model of menopause. The model has two basic assumptions, representing
women for whom menopause means little change, and women for whom menopause
means significant change. It also includes five construing patterns, the last of which is
a pattern for therapeutic intervention.

Chapter 5 is a report of Study 1, an exploration of the meanings of menopause. I
describe the design, methodology, and procedure, of the study, followed by the
findings, which are presented in a number of ways. Firstly, I present the themes that
were identified in women’s meanings of menopause, describing them in order of
frequency. Next I provide a summary of responses to each interview question, and
then a summary of responses to each research question. I then discuss women’s
responses according to their menopausal status, that is, whether women identified
themselves as premenopausal, menopausal, and postmenopausal. The discussion of
the data concludes with the women’s responses to my post-interview report. Finally, I
discuss the limitations of the study.

Chapter 6 is an examination of psychologically based, or educational,
interventions and workshops for menopausal women. The vast majority of
interventions for menopausal women are medically-based prescriptions for hormone
therapy, and the evidence of other forms of intervention is relatively slight. Drawing
on the menopausal literature, I evaluate psychologically-based groups and workshops
for menopausal women, and then educational groups and workshops. Finally, I discuss
the limitations of reported interventions for menopausal women.

Chapter 7 is a discussion of personal construct approaches to therapy and
workshops. Firstly, I briefly describe personal construct approaches to therapy and
therapeutic movement. I then summarise personal construct approaches to group
therapy, including group processes, strategies for group work, therapeutic factors, and the evaluation of change. Finally I describe a three-session Menopause Workshop, based on a personal construct approach, designed for women anticipating, or experiencing, menopause.

In Chapter 8 I describe Study 2, a study of menopause, emotion and reconstruction, in which I evaluate the Menopause Workshop. I provide the research framework, aims, theoretical assumptions, and hypotheses, followed by the methodology, design and procedure. I present the findings of the statistical analyses in two parts: firstly a comparison of two groups of women, with differing levels of distress, who took part in the workshops; and secondly, a comparison of the two workshop groups of women, with a third, contrast group of women, who took part only in data collections. Finally, I comment on the findings, and the limitations of the study.

In Chapter 9 I describe some of the processes of the menopause workshops, to give a more vivid picture of the women’s changes in construing. I give a brief account of some personal construct issues in relation to the approach to experimentation. I also discuss issues relevant to working with existing groups, drawing attention to both the advantages and challenges this entails. In this discussion I comment on the impact of workplace hierarchies and other workplace interactions, and the difficulty of balancing individual and group needs. I then provide a brief account of the workshop sessions. Next, I present samples of my diary records of the workshops, and also case study examples, based on my diary records, to provide illustrations of the ways in which group members were able to aid each other towards changes in construing. I also provide examples of changes in women’s cognitive anxiety scores as a means of confirming the qualitative indications of reconstrual. The following section consists of four case studies, included to illustrate women’s progress from initial interview in
Study 1, through the processes of the workshops, to the final follow-up in Study 2. In the next sections I summarise the women’s responses given in the Participant Evaluation Sheets, and in response to the Report to Participants. The final section consists of my reflections on the processes of change in women anticipating or experiencing menopause, who took part in Study 2.

Chapter 10 concludes the main body of the thesis, and here I reflect upon the implications of the findings of Studies 1 and 2, and comment on the limitations of this research. I also discuss the implications of the findings for the personal construct psychology model of menopause, and the Menopause Workshop. In addition, I comment on the implications of the research for working with women construing the menopausal transition. In conclusion, I provide ideas for the directions of future research.

1.5 The Writing Conventions used in this Thesis

There are numerous references to, and quotations from, *The Psychology of Personal Constructs* (Kelly, 1955/1991a; 1955/1991b) in this thesis. I have endeavoured to attribute the source of these clearly, but without undue repetition. The convention I have adopted is: In paragraphs where multiple quotations from this work occur, at the first reference, I have cited the date, the precise volume, and the page on which the quotation occurs. Within that paragraph, I have then given only the page numbers of quotations from the same volume. At the first reference in the next paragraph, I have again indicated the date, volume number, and the page number, followed by page numbers for succeeding quotations within that paragraph. When a quotation from another source occurs between quotations from Kelly, I have given the date, volume number, and page for the first reference to Kelly after the other author.
Quotations from Kelly (1955/1991a; 1955/1991b) are, of course, reproduced as they were written, with some inevitable dissonance between the masculine gender habitually used by Kelly, and the exclusively female nature of the research.

Any material that I have added to quotations, for example, to explain a word, is contained within brackets [ ].

1.6 Confidentiality Issues

In order to protect the confidentiality, and preserve the anonymity, of the women who took part in this research, I used numbers to distinguish the women during data collection and transcription procedures. I then assigned pseudonyms to the identification numbers, using only names that were not held by any woman taking part in the research. It is these pseudonyms that I have used to distinguish women throughout this document.
CHAPTER 2

THE CHANGE OF LIFE: CONCEPTUALISATIONS
OF MENOPAUSE
In this Chapter I describe a set of conceptualisations of menopause. I start with a medical definition, followed by an historical perspective of views on menopause. I then discuss four models of menopause: the medical model, the sociocultural model, the feminist model, and the green or natural life model. I follow that with an outline of theories of menopause in developmental and abnormal psychology, and a discussion of the psychology of women, and the contributions of relevant women psychologists. I briefly discuss popular representations of menopause, and conclude with the limitations of current conceptualisations.

2.1 Definitions of Menopause

The menopause, defined as the cessation of menses, is a universal phenomenon for those women who live until an appropriate age. In contrast, the universality of manifestations of menopause, such as physical and psychological symptoms, is hotly debated (Oddens, 1994), and the only sign of menopause on which there is complete agreement is the cessation of periods (Notelovitz, 2003).

In 1976 the first agreed international definition of menopause was achieved at the first International Menopause Congress. The definition was in three parts: defining the climacteric as “the phase in the aging of women marking the transition from the reproductive phase to the non-reproductive state,” and the menopause as “the final menstrual period” (Utian, 1991, p 1). The authors of the definition went on to note that: “the climacteric is sometimes, but not invariably associated with symptomatology,” and that “climacteric symptoms and complaints result from decreased ovarian activity with subsequent hormonal deficiency … sociocultural factors … and psychological factors” (Utian, 1991, p 1). This definition encapsulates the view that the symptomatology of the menopause may vary in different educational, socioeconomic, ethnic and cultural groups. In 1986, a standard definition of natural menopause was suggested as “at least
12 months’ amenorrhea [no menstruation], not obviously attributable to other causes” (Utian, 1991, p 2).

In 1999, the Council of Affiliated Menopause Societies (CAMS), the policy arm of the International Menopause Society (IMS), agreed on a new international definition (North American Menopause Society, 2000b, p 14). Natural or spontaneous menopause was defined as: “the permanent cessation of menstruation resulting from the loss of ovarian follicular activity. Natural menopause is recognised to have occurred after 12 consecutive months of amenorrhea, for which there is no other obvious pathologic or physiologic cause. Menopause occurs with the final menstrual period, which is known with certainty only in retrospect a year or more after the event. An adequate independent biological marker for the event does not exist” (North American Menopause Society, 2000b, p 14), that is, no one can know that they have experienced menopause at the time of the event. In the Western world, menopause occurs at a median age of 51.4 years (North American Menopause Society, 2000b).

According to the Council (CAMS), the term induced menopause is defined as “the cessation of menstruation that follows either surgical removal of both ovaries (with or without hysterectomy) or iatrogenic ablation of ovarian function (eg, by chemotherapy or radiation)” (North American Menopause Society, 2000b, p 16), and “surgical menopause” refers to induced menopause caused by surgical removal of both ovaries (North American Menopause Society, 2000b, p 16).

Premenopause “is often used ambiguously, either to refer to the 1 or 2 years immediately before menopause or to the whole of the reproductive period prior to menopause” (North American Menopause Society, 2000b, p 15). CAMS recommends that this term “should be used consistently in the latter sense, and should encompass the entire reproductive period up to the final menstrual period” (North American Menopause Society, 2000b, p 15). However, CAMS has indicated that this term “can be
confusing and preferably should be abandoned” (North American Menopause Society, 2000b, p 15).

The term *perimenopause* includes:

“the period immediately prior to menopause (when the endocrinologic, biologic, and clinical features of approaching menopause commence) and the first year after menopause …. The median age for the onset of perimenopause is 47.5 years. For most women, perimenopause lasts approximately 4 years. Only about 10% of women cease menstruating abruptly, experiencing no menstrual irregularity. Perimenopause is the correct term for what some call ‘being in’ or ‘going through’ menopause” (North American Menopause Society, 2000b, p 15), and “refers to the time period around menopause” (North American Menopause Society, 2000a, p 5).

According to the Council (CAMS), the term postmenopause is defined as:

“dating from the final menstrual period, regardless of whether menopause was induced or spontaneous,” and the term climacteric describes: “the phase during the aging of women marking the transition from the reproductive phase to the nonreproductive state. This phase incorporates the perimenopause by extending for a longer, variable period before and after the perimenopause” (North American Menopause Society, 2000b, p 17). Thus, the climacteric is a process, rather than a specific point in time.

The Council adds that: “the climacteric is sometimes, but not necessarily always, associated with symptomatology. When this occurs, it may be termed the climacteric syndrome” (North American Menopause Society, 2000b, p 18). In the educational material produced by the North American Menopause Society, the Society is careful to point out that “menopause is a natural biologic event, not a disease or an ‘oestrogen deficiency disease’. Menopause represents the permanent cessation of menses resulting from loss of ovarian follicular function. Menopause is also a
psychosocial passage” (North American Menopause Society, 2000b, p 13). There is a subtle difference between this definition and the earlier one. The earlier incorporation of sociocultural and psychological factors into the definition of the climacteric has been replaced with the notion of a psychosocial passage, a move away from the definition of symptoms. I shall return to these definitions in Section 2.3.1, which describes the medical model.

Despite the publication of the international definition, the terms premenopause, perimenopause, menopause, and postmenopause continue to be used ambiguously (Mitchell, Woods, & Mariella, 2000), and are confusing, especially for women themselves. The menopause is something that is, by definition, known with certainty only in retrospect. Only after that is it clear that a woman is postmenopausal. Similarly, unless a woman’s hormonal levels are constantly tested, it is unclear how a woman would know whether the perimenopause had started, and how it would be distinguished from a premenopausal state. In this research women were often unclear about how they should use these terms.

2.2 An Historical Perspective on Menopause

It is generally accepted that the word menopause is derived from the Greek words men (month) and pausis (cessation) (Utian, 1997), but it is of recent origin, first appearing in the 19th century (Formanek, 1990). According to Utian, the word climacteric also appears to be of Greek derivation, representing the word for ladder or steps of a ladder (Utian, 1997). Although they are infrequent, references to menopause have been recorded for more than 2000 years. Aristotle wrote that menstruation ceased for the majority of women at forty, but added that it could last up to the fiftieth year (Blundell, 1995). There is a reference to a woman being past reproductive age, or postmenopausal, in Chapter 17 of Genesis in The Old Testament: “Abraham laughed
when God promised to give him a son, because he was a hundred years old, and his wife Sarah was 90” (Genesis: 17).

Pre-modern descriptions of menopause are not common, possibly because average life expectancy was such that the majority of women would have died before reaching menopause. For example, in much of the ancient world the average life expectancy at birth is assumed to be below 25 years (Parkin, 1992), although this average should not obscure the fact that some women lived to what is now considered old age (Lock, 1998).

Attitudes to menopause may well have varied depending on cultural practices, but, as today, often there were multiple meanings for menopause and aging. On the one hand there are depictions of crones in Greek mythology, such as Atropos, the eldest of the Fates, who cut the thread of life, and the Graiae, three sisters who were grey-haired from birth, and shared one eye and one tooth (Hammond & Scullard, 1970). On the other hand, the requirement of virginity of the priestesses of the Delphic Oracle, later became a requirement for them to be over 50 or “elderly” (Hammond & Scullard, 1970). Older women had the spectre of the crone before them, but could also fill a revered place in society. Both of these meanings, fear of becoming a crone and attaining a “wise woman” status, are still reflected in current studies of menopause, as I note later in this chapter.

In many cultures, menopause may have come as a relief to women, since deaths in child-birth contributed to the low life expectancy for women throughout pre-modern societies. In addition, although women who attained a suitable age lost their fertility and perhaps some value, they may also have welcomed freedom from excessively negative views of menstruating women. From the later Roman culture, Pliny for example, wrote: “women, hardly can there be found a thing more monstrous than is that flux and course of theirs” (Turner, 1962, p 83). According to Pliny, wine, corn, grass,
herbs, fruit, mirrors, swords, knives, ivory, iron, steel, brass could all be ruined, dogs sent mad, and bees killed, by the presence of a menstruating woman (Turner, 1962, p 83), however her naked belly could also scare away hailstorms, whirlwinds and lightning (Turner, 1962, p 278), a heavy burden to carry. Fears of this kind have survived for millennia in less extreme forms. Klein (1975/1946), in 1946, asserted that the taboo attached to “woman’s ‘uncleanliness’ lived on in feelings of shame and … numerous myths, such as the belief that a menstruating woman cannot … preserve fruit or jam [and that] similar superstitions still survive in the popular mind” (1975/1946, p 96). Similarly, Beyene (1986) in a study of both Greek and Mayan women reported taboos associated with menstruation which restricted women’s activities. Similar beliefs were reported in the year 2000, in this research, when a Greek woman reported that it is still the practice that women are not allowed to touch the icons at church whilst menstruating, a source of some embarrassment. Again, these themes of freedom from menstruation and childbirth are reflected in current studies of menopause.

There is relatively little information about women in general in late antiquity, as the sources are predominantly law codes, medical texts, and church writings which tend to be prescriptive rather than descriptive (Clark, 1993). It is possible that there was some understanding of menopause demonstrated by the older ages at which women were allowed to become deaconesses (Clark, 1993), an interesting parallel to the Delphic Oracle.

Formanek (1990) has reviewed pre-modern views of menopause, finding that in medieval times the theory of humors influenced explanations of the body. Although menopause was not mentioned, “amenorrhea, or suppressed menstruation,” was considered the chief cause of women’s illnesses” (, p 6), a view still reflected in some cultures (Beyene, 1986; Gifford, 1994). In the 18th century, a distinction was made between amenorrhea and menopause, and menopause was described as a natural stage
of life with no ill effects (Formanek, 1990). This “natural approach” has continued to
the present day, but came to be rivalled in the 19th century by a view that menopause
was a dangerous time of life, and that women were “vulnerable to mental and physical
illness” (Formanek, 1990, p 10).

Utian (1997) cites a number of 19th century medical sources in which
menopause was linked with symptoms of illness such as cancer and gout, as well as
descriptions of “decay” and loss of “personal attractions” (Utian, 1997). At the
beginning of the 20th century, a medical textbook was still stating that at menopause a
woman was “doomed, with cruel abruptness, to be to her husband merely an intellectual
companion or a sexless helpmate …. One third of her adult life is still before her … the
future stretches a dreary waste of empty years” (Reed 1904, cited in Chornesky, 1998).

The association of menopause with psychological or physical illness has been a
powerful notion in Western culture, and a number of writers have drawn attention to the
links that have been made between women’s biological functions and illness,
particularly in relation to the growth in importance of the medical profession
(Ehrenreich & English, 1978; Showalter, 1985; Wood, 1974). It has been asserted that
conceptually, the medicalisation of menopause occurred in the 1930s and 1940s,
because of developments in endocrinology and research medicine (Bell, 1990). The
association of menopause with illness has continued, with references to “tragedy,”
“deficiency disease,” and “misery” appearing in medical accounts of menopause as
recently as 1967 (Utian, 1997).

The existence of rival meanings of menopause is strongly reflected in women’s
meanings today (Foster & Viney, 2001). It appears that menopause has always had
multiple meanings: for the doctors and philosophers who have written of menopause it
has meant either a natural occurrence or a pathological condition; for women it has
meant the loss of youth and fertility, and therefore perhaps value, but also the gaining
of freedom from menstruation and childbearing, and an improvement in status in some cultures (Chornesky, 1998; Ismael, 1994).

2.3 Models of Menopause

A number of writers have attempted to identify the dominant models of discourse within which menopause researchers work. Coupland (2002) proposed three models of menopause that influence women’s own interpretations: pharmaceutical, alternative therapy, and emancipatory feminist discourses. O’Kane (1998) suggested that menopause research was carried out using biomedical, socio-cultural, or feminist approaches. Another analysis proposed three models: the biological model, the psychosocial model, and the holistic or integral model (Olazabal Ulacia, Garcia Paniagua, Sendin Melguizo, & Holgado Sanchez, 1999), and recommended adoption of the holistic model to improve the care given to menopausal women. Woods (1998) held that only two models of menopause have shaped western society’s views, believing that: “models not only describe but also prescribe the meaning of the menopause for women and the society” (p 5). The first model “characterizes menopause as a nonadaptive event,” emphasizing “the biological reproductive function of women wherein women complete their social responsibility with the onset of menopause” (p 5). The other model “characterizes menopause as an adaptive event wherein women can contribute more to the society when they cease to ovulate” as they are freed “for participation in the work of society beyond the boundaries of their families” (p 5).

I shall discuss four models that I have identified in scientific and popular writing on menopause: the medical model, the socio-cultural model, the feminist model, and the green or natural life model. These models are not mutually exclusive, but represent approaches that intersect and overlap.
It is apparent from the literature on menopause that current research focuses strongly on the symptomatology and management of menopause. Although there have been calls for integrative perspectives (Woods, 1994), and attempts to undertake research using a multidimensional approach (Berg, 1999), broadly speaking, most research is undertaken within the frameworks of two models of menopause: a medical, biologically based model and a sociocultural model (Woods, 1998).

2.3.1 The Medical Model

To date, the information on menopause available to women through the public media or through expert consultation has largely been that generated within the medical model. The definitions that I provided earlier were written within a medical context, and derive their authority from that context. The sentence “perimenopause is the correct term for what some call ‘being in’ or ‘going through’ menopause” (North American Menopause Society, 2000b, p 17) is a direct reference to the authority of the definition.

Recently, menopause organisations have presented a more broadly-based approach. The North American Menopause Society (North American Menopause Society, 2000b), for example, asserts, in the definition of menopause, that it “is a natural biologic event, not a disease or an ‘oestrogen deficiency disease’, ” and refers to the idea that “menopause is also a psychosocial passage” (p 13). Despite such moves, generally speaking, the medical model provides a symptom-based analysis of women’s experiences, and focuses on the identification of both physical and psychological symptoms linked with menopause, and the consequent management of menopause and menopausal symptoms (Farrell & Westmore, 1993).

Greene (1998), for example, developed a standard climacteric scale of 21 items in reaction to the “lack of a standard instrument to measure the range of symptoms most commonly experienced by women at that time of their lives” (p 25). Greene comments
that Neugarten and colleagues, in 1963 provided an early example of a list of menopausal symptoms, and that since that time many, fairly ad hoc, lists have been compiled (Greene, 1998). An Australian study recorded a list of 50 symptoms that had been reported in the literature as menopausal (Abraham, Llewellyn-Jones, & Perz, 1995).

Research continues into the relationship between menopause and a wide range of physical symptoms such as hot flushes (Berendsen, 2003; Reynolds, 1997), bone loss (Sirola et al., 2003), cardiovascular risk factors (Castelo-Branco et al., 2003), cognitive function (Kritz-Silverstein, Von Muhlen, Barrett-Connor, & Bressel, 2003; van Duijn, 1999), arthritis (Wluka, Cicuttini, & Spector, 2000), weight gain (Park & Lee, 2003), eye complaints (Metka, M., Enzelsberger, H., Knogler, W., Schurz, B., & Aichmair, H., 1991), and headaches (Neri et al, 1993). A number of studies have also investigated menopause and sexuality, in some cases finding a decline in sexual interest (McCoy, 1998), but in others, that female sexual functioning was not affected by age (Dennerstein, Dudley, Hopper, & Burger, 1997; Hunter, 1990).

There are few certainties in menopausal research, and some researchers have drawn attention to methodological problems, such as the use of different populations, that have contributed to these conflicting findings (McKinlay, Brambilla, & Posner, 1992). In 1992 Greene (1992) published a paper summarizing cross-sectional studies at that time. He found two points of agreement. Firstly, that the outcome of 16 cross-sectional studies showed a “marked temporal association of vasomotor symptoms with the menopause,” although he made the qualification that “only a minority or women experience any general distress” (p 97). Secondly, that this minority of women “can be identified by certain social and psychological characteristics” (p 97). Greene’s conclusion was that it was “underprivileged women of low sociodemographic status, low family income, low educational level and with limited employment opportunities
who suffer most during the climacteric” (p 97). He notes in relation to this cluster of characteristics that Severne found that employment was beneficial only if it was career orientated or intrinsically rewarding, rather than an economic necessity, a conclusion supported by evidence from Europe (Caycedo & Rollins, 1989). In terms of personal psychosocial factors he found that “negative attitudes to the menopause, poor social support, poor marital relations, stressful life events and recent bereavement have all been found to be associated with symptoms” (p 98).

Greene proposed a “vulnerability model” of the climacteric, that is, that the presence of “adverse sociodemographic and psychosocial factors renders such women vulnerable … to develop non-specific physical and psychological symptoms” (p 99). The question of whether these conclusions would be confirmed by later research was left open. The obvious issue of whether negative attitudes to menopause had arisen before or after the occurrence of symptoms was not examined, nor was how a “negative attitude to menopause” had been assessed. The attribution of the cause of symptoms to the woman herself is a continuation of a long tradition in medical practice of explaining women’s bodies by references to women’s minds, and has been frequently identified by feminist scholars (Ehrenreich & English, 1978; Sybylla, 1990). Leidy (1997) observed that “women who have never experienced a hot flash believe that women who complain about hot flashes are ‘complainers’ about other things as well” (p 154), and that doctors also informally used this description. Her research investigated the relationship between the reporting of other discomfort and hot flushes, with a finding that there was no evidence that hot flushes were more likely to be experienced by “complainers” (Leidy, 1997).

A recent study compared the experience of vasomotor, psychological, and somatic symptoms in Australian men and women in midlife (Calvares & Bryan, 2003). The study found that “health and psychological well-being play a role in the genesis of
symptoms experienced by men and women in midlife” (p 225), although women are more distressed by their symptoms. The authors claim that this finding signifies support for “a menopausal syndrome in women” (p 225). They also found an “independent relationship between menopausal status and psychological and somatic symptoms” (p 225) as distinct from vasomotor symptoms. Peterson and Schmidt (1999) reported on a longitudinal study of perimenopausal women, aged 35-54 years. These women were matched with three sets of age-defined controls. The findings were that changes unique to perimenopause status included sleep and sex difficulties, and chemical changes.

Hom et al (2003) investigated whether social and health factors were independently associated with overall symptom reporting. They found that “currently not working, decreased household income in the past year, worry over friends/relatives, and health affecting daily activities” (p 149) were independently associated with symptom reporting. Researchers have noted that uncertainty remains “regarding what health symptoms can be directly attributed to the menopause” (Hardy & Kuh, 2002, p 1975). Hardy and Kuh (2002) reported on a study of 1572 British women who were born in 1946. Their findings suggested that “vasomotor symptoms are dependent on changing hormone levels associated with the menopause, while psychological symptoms are not” (p 1975). They found, however, that there was an increase in symptoms in premenopausal and perimenopausal women starting hormone replacement therapy. They raised the possibility that there is a small subgroup of women who experience increased psychological problems at the time of menopause, and who, in that study, were identified by the use of HRT.

Differences in symptom reporting between a variety of populations leads to a continuing interest in the connection between the mind and physical symptoms. A recent article titled “Mind Control of Menopause” (Younus, Simpson, Collins,
Wang, 2003), tested the efficacy of hypnosis in relation to vasomotor and other symptoms. Four sessions of hypnosis, for one-hour per week, were conducted. The findings were that hot flushes, quality of life, and sleep were improved. The study, however, was conducted with a total of 14 participants, with no control group, and relied on self-report measures to assess the effectiveness of the intervention.

Although some researchers acknowledge that many women do not report the menopausal transition as problematic (Avis & McKinlay, 1991; Kaufert, Gilbert, & Tate, 1992; Morse et al., 1994), the focus of the medical model is on symptoms, pathology, and intervention. This is the case, even when researchers advise that women’s individual differences should be taken into account (Col et al., 1999). The debate about menopausal symptoms has two aspects. On one hand, as I have observed above, there are many critics of the medical emphasis on menopausal symptoms. On the other hand, some women report difficulty in having their menopausal symptoms recognised by the medical profession.

Goldstein (2000) has reported on an internet health support group alt.support.menopause, which, together with another internet group, menopause, has compiled a reference list of “the signs of menopause,” which the women in the groups recommend be written on a card for women to “give to their physicians” (p 317), with a suggestion to the doctor that the list be consulted whenever a woman over 30 sought advice (p 317). This action was recommended because the experience of the women developing the list was “misdiagnosis by a physician or psychiatrist and often years of anxiety about the symptoms and inappropriate treatment” (p 317). Other women also report unsatisfactory experiences with doctors (Komesaroff, 1999). In Chapter 5, I shall refer to similar concerns of the women in this research. It is rare to find a record of women’s construing in relation to the debate on menopausal symptoms, so it is interesting that this list, compiled by women themselves, includes thirty-three items
ranging from physical symptoms such as hot flushes, to psychological symptoms, such as anxiety or feelings of dread. Goldstein also reported that members of the group “frequently discuss the difference in the nature of many of the symptoms when hormonally caused rather than as caused by other aetiologies” (p 318). She quotes a member’s perceptive comment in relation to medical researchers, “as far as I can see they are relating verbal accounts or subject reports through questionnaires to equate what are subjectively very different events” (p 318). Goldstein (2000) found that members of the support groups demonstrated remarkable consistency and agreement in their description of symptom clusters, cause and relief. She argued for the use of self-help groups to understand notions of health and illness, and the menopausal syndrome.

The group she reported on is, of course, not a randomly selected group. One of the members of the group, reported on by Goldstein (2000), characterised the group by saying “we are a self-selected biased group skewered [sic] towards the top end of educational and socio-economic groups and the bottom end of menopausal comfort” (p 316).

The dominance of the medical model has been questioned (Caltabiano, 1998) on the basis that the majority of menopausal women in western society do not use hormone replacement therapy. Certainly, some research has found that many women do not consult their health-care providers about hormone therapy or alternatives (Conboy, Domar, & O’Connell, 2001). Other studies, however, report quite high usage, depending on socioeconomic status. In 1994, Oddens reported that 20% of perimenopausal women in Western Europe used HRT, and other studies, such as a Chilean study (Blumel et al., 2002), reported a very high use of HRT among women of high socioeconomic status. A French study also found that the proportion of HRT users increased with socio-economic status (Fauconnier, Ringa, Delanoe, Falissard, & Breart, 2000). This last relationship is perhaps also connected to the finding in that study of a
relationship between women's level of beauty care and hormone replacement therapy use (Fauconnier et al., 2000). An Australian study in 1998 (Turner, 1998) reported 44.1% of women in a community based study using hormone replacement therapy. A recent study of gynaecologists in the United States and Israel found that 92% of physicians routinely offered HRT to menopausal patients, with American doctors also more inclined to recommend diet supplements such as vitamins and calcium (Kaplan et al., 2002). An interesting study of the change in doctor’s prescribing patterns was undertaken in Sweden where a longitudinal study found that in the 1960s sedatives and anticholinergic drugs were prescribed for menopausal women, whereas hormone replacement therapy has been the predominant medication prescribed since the 1980s (Rodstrom et al., 2002). A recent interest in the medical literature has been women’s non-compliance with, or discontinuation of, hormone replacement therapy regimes (Reynolds, Obermeyer, Walker, & Guilbert, 2002).

The overwhelming majority of published menopausal research is undertaken, and funded, within a medical context, and a recent Australian study confirmed that while women use more than one model to view menopause, the most dominant was the medical model (Webster, 1998). A study of Australian women in 2001, however, found that, contrary to popular beliefs, women thought menopause signified wellness (Berger & Forster, 2001).

From a psychological perspective, Leitner's critique of psychiatric nosology is applicable to the medical model of menopause, as within the model there is a focus on the construing of symptoms rather than the construing of persons. The clinician “may be more interested in completing a checklist of symptoms than in understanding the inner experience of the person … alternatively, the therapist may assume knowledge of the inner person based upon the diagnosis” (Leitner & Faidley, 1999, p 99). For example, a link between women’s vasomotor symptoms and their stress-coping ability
was reported in a study of thirty-three women (Nedstrand, Wijma, Lindgren, & Hammar, 1998) and another study reported that a poor mental health index was associated with women reporting menopausal symptoms (O'Connor et al., 1995).

Winter (1992) has drawn attention to Kelly’s (1955/1991a, 1955/1991b) opposition to the medical model of psychological states, and to Kelly’s belief that it involves a preemptive construction of clients. This preemptive type of construction characterises much medically-based research into menopause, in which it appears that, as Kelly (1955/1991b) said, “diagnosis is all too frequently an attempt to cram a whole live struggling client into a nosological category” (p 775).

In this chapter, I have noted medical concerns about the potential health problems of ageing women, and these are becoming an increasingly pressing issue for health systems (Butler, Collins, Meier, Muller, & Pinn, 1995; Crose, 1995; Kaveny, 1998). Despite this, Kaveny (1998) has observed that there is a lack of visibility of older women in social justice platforms, such as the 1995 Declaration and Platform for Action of the Fourth United Nations Conference on Women. This may simply stem from the fact that an ageing population is predominantly an issue in industrialised countries, rather than a worldwide problem. Alternatively, it may indicate a lack of connection between the medical and social justice sectors.

In summary, researchers working within the medical model define menopause in terms of biology, using a symptom-based analysis to describe women’s experiences. The symptoms that are identified are then treated by prescription of medications such as hormone therapy.

2.3.2 The Sociocultural Model

Parallel with, but not as powerful as the medical model, a sociocultural model of menopause has developed. Research within this model identifies the roles played by cultural context, social role, or lifestage in women’s experience of menopause. Many
studies record 20th century cultural beliefs about women’s biological functions that
directly reflect the historical beliefs discussed earlier in Section 2.2. For example,
research in Thailand suggested that more than 80% of women wish to decrease or stop
sexual activity after menopause (Chompootweep, Tankeyoon, Yamarat, Poomsuwan, &
Dusitsin, 1993). Themes such as freedom from menstruation and childbirth, fears of
aging, and the gaining of wisdom, remain current.

Cross-cultural menopause research was conducted in the 1970s by Dowty and
colleagues (1970), with an increasing number of studies since that time. This type of
analysis is provided in, for example, *Cross-Cultural Perspectives on Menopause*
(Robinson, 1996); *Multicultural Perspectives on Menopause and the Climacteric*
(Chornesky, 1998); *Psychosocial Determinants of Climacteric Complaints* (Holte &
Mikkelsen, 1991b), in which traditional sex role identification was linked with nervous
complaints; and *The Menopausal Experiences of Women in a Developing Country:
There Is a Time for Everything: to Be a Teenager, a Mother and a Granny* (McMaster,
Pitts, & Poyah, 1997), in which particular cultural beliefs about social roles and
lifestages are described in relation to the way they impact on women’s understandings
and reactions to the menopause. There are at least two strands in these writings: cross-
cultural research undertaken from the perspective of the medical model (Boulet,
Oddens, Lehert, Vemer, & Visser, 1994), and sociological, anthropological, or
ethnographic research (Beyene, 1986; Lock, 1986; McQuaide, 1998b).

Much cross-cultural research has been undertaken from a medical perspective,
an intersection of the medical and sociocultural models. In the 1990s there was a clear
effort by the medical establishment to incorporate cross-cultural research into the
medical framework. In this type of research, the focus is again on symptoms.

It has been suggested that some apparent cross-cultural differences may result
from climate, that is, the difficulty that women in hot climates may have in
distinguishing between hot flushes and the sensation of heat or sweating caused by hot
weather (Punyahotra, Dennerstein, & Lehert, 1997). The evidence for women in hot
climates is contradictory. Sukwatana and colleagues (1991) found that increased heat
intolerance was a common menopausal symptom for Thai women. In India, Sharma
and Saxena found that hot flushes, night sweats and insomnia were clearly associated
with the menopause (Sharma & Saxena, 1981). An Indonesian study found that
menopausal complaints were rare, but 69% of respondents were premenopausal, and it
is not clear whether the results related to the whole sample or to perimenopausal
women (Samil & Wishnuwardhani, 1994). Another Indonesian study found that 83%
of women were affected by climacteric symptoms (Ramosa-Jalbuena, 1994).

In 1994, the results were published of a survey of the climacteric in seven
south-east Asian countries, carried out by the International Health Foundation (Boulet
et al., 1994). The survey was carried out in Hong Kong, Indonesia, Korea, Malaysia,
the Philippines, Singapore, and Taiwan, and took special care to overcome linguistic
and cultural problems. The results showed that climacteric symptoms were
experienced in South-East Asian countries, although in a milder form than in Europe
and America. Boulet and colleagues (1994) reported that the percentages of women
reporting psychological complaints were relatively high, and that the symptoms might
indicate “general distress experienced around … the time of the menopause in these
countries” (, p 172). The researchers concluded that “vasomotor-complaint-related
distress might be ‘translated’ into psychological complaints, which are more frequently
considered to warrant consulting a physician” (Boulet et al., 1994, p 157). This was
both a warning of the difficulties of interpreting cross-cultural findings, and another
assertion of a medical interpretation of menopausal experience. Other cross-cultural
studies, undertaken from a medical perspective, have found symptom-reporting similar
to that in developed countries, in, for example, the United Arab Emirates (Rizk, Bener,
Ezimokhai, Hassan, & Micallef, 1998), Thailand (Chompootweep et al., 1993; Sukwatana et al., 1991), Mexico (Malacara et al., 2002), and Tanzania (Moore & Kombe, 1991), and that it is similar but at a somewhat lower frequency in Singapore (McCarthy, 1994).

In 1999, a review of available research on menopause in different cultures, carried out by the Mid-Link Menopause Service in Sydney, found that research exploring cross-cultural differences reveals many contradictions and “raises more questions than answers” (Ryan, 1999, p 1). The study found, however, that despite conflicting results, “there appears to be sufficient evidence to support the likelihood that the symptomatology of menopause varies across cultures” (Ryan, 1999, p 3). Ryan (1999) found that studies attributed cross-cultural differences to three factors: women’s sociocultural status at menopause; the effects of diet and climate; and cultural differences in the acceptability of symptom reporting, relating to religious beliefs, the imperatives of survival, or simply lack of knowledge.

A common finding among cross-cultural researchers is the identification of a relationship between socioeconomic status and women’s symptom reporting. Tang (1994) found that markedly fewer Chinese factory workers in Hong Kong, 18% of women, had hot flushes, compared to the estimate of “up to 85% of western climacteric women” (Oddens, 1994, p 155). It is unclear, however, whether the statistic of 18% refers to the entire sample or not. This is important, as 59% of the sample was premenopausal. The researcher concluded that: “women’s interpretation of the menopause probably reduces its symptomatology” (Tang, 1994, p 182), and noted that economic hardship might divert women’s attention from symptoms, especially as taking time off to see a doctor would mean a reduction in salary. Later studies, however, again found that the prevalence of hot flushes in Hong Kong Chinese women
was lower than that reported in Caucasian populations (Haines, Chung, & Leung, 1994; Ho et al., 1999).

Wasti (1993) raised a similar issue to that raised by Tang (Tang, 1994), finding class differences in the reporting of symptoms in Pakistan, with one in two women in middle class and privileged groups, but only one in five women in the poorest group, reporting symptoms. The researchers commented on the possible: “capacity of the individual to overlook minor symptoms when faced with major socioeconomic problems” (Wasti et al., 1993, p 68). In Thailand, in contrast, researchers found that “lower education and unemployment were associated with greater frequency of complaints” (Punyahotra et al., 1997, p 2).

Oddens (1994), in an editorial in Maturitas, the journal of the European Menopause Society, proposed that “the belief that cultural values attributed to the menopause in non-western societies prevent women from experiencing distress in this phase of life are too narrow … the climacteric may be burdensome to women, whatever their cultural context …. Reducing the climacteric to hot flushes only or to a cultural behavioural disorder will certainly not be sufficient for a good management of this period in the life of a woman” (Oddens, 1994, p 156). This summation is a useful warning in relation to cross-cultural research, but it is still an assertion of a medical interpretation of menopausal experience, and the necessity of medical management of that experience.

Social factors also play a role in the construction of meanings of menopause (Ferguson & Parry, 1998). A study of Italian-Australian women found that the change of life was experienced as the end of life in a social sense (Gifford, 1994). Similarly, research with Arabic-Australian women found that menopause was predominantly seen in a negative light, as desperate hopeless years (Ryan & Marek, 1999). Some women
may find menopause “inconsequential because other events of midlife are more
important or stressful to them” (Winterich & Umberson, 1999).

An interesting study of the interface between traditional beliefs and modern
health practices was presented by Chirawatkul (1994). This ethnographic research
found that village women in Thailand “generally … welcome what they regard as
freedom from the burdens of menstruation, pregnancy and childbirth” (p 1548) and the
opportunity “to go to the temple without the anxiety of menstruation” (p 1549). These
statements were made even though menopause was also a marker of ageing. The
experience of menopause for these women proved to be highly individual, and yet it
was regarded as a natural event. The researchers found, however, that in the women’s
interactions with health personnel, “these understandings are challenged by biomedical
representations of menopause, the publicity give to HRT within the popular press in
Thailand, and by diagnostic and prescriptive practices that have medicalised menopause
as a problem of oestrogen deficiency” (p 1553). Similarly, a study in Mexico found
that: “the medical definition of menopause did not coincide with the women’s
definition” (Mingo, Herman, & Jasperse, 2000, p 27). These studies illustrate the
contested nature (Lock, 1991) of the meanings of menopause reflected in many
personal debates (Foster & Viney, 2001).

The research, that above all seems to have had a lasting impact among members
of the general public, was published by an anthropologist, Margaret Lock (Lock, 1986),
who investigated Japanese women’s experience of menopause. Lock found that
Japanese women reported significantly less vasomotor symptoms, such as hot flushes,
than European or North American women. This research generated a great deal of
interest, and Lock continues to develop her theme (Lock, 1991, 1998), and offer
rebuttals to her critics (Lock, 1995). In my research, the only cross-cultural reference
that the women volunteered that they had heard was that Japanese women had fewer
symptoms than women in Western societies. These women most often attributed this to the high intake of soy products in the Japanese diet.

Unfortunately, although Lock warned of the care that must be taken in regard to cross-cultural research (Lock, 1991), in some instances her work reinforced the association of menopause with psychological symptoms. It seemed to present evidence for the notion that menopause symptoms were culturally specific, and since it has been claimed that “vasomotor symptoms are reported by up to 85% of western climacteric women” (Oddens, 1994), was interpreted by some as evidence that women in western cultures suffer from psychological complaints rather than physical symptoms (Wilbush, 1982). A number of other studies are also cited, with that of Lock (1986), as evidence that commonly reported symptoms of menopause are not universal, particularly research with Mayan Indian women (Beyene, 1986; Martin, Block, Sanchez, Arnaud, & Beyene, 1993), Canadian Sikhs (George, 1988) and Rajput women (Flint, 1975).

There are methodological issues linked with cross-cultural research which have not yet been adequately addressed with a wide enough selection of samples for definite conclusions to be drawn from the studies available at this stage. For example, the findings of Lock (1991), cited above, may owe as much to cultural differences in symptom reporting, as to diet. Japanese women complained of stiff shoulders, and a range of other symptoms associated with age, but not hot flushes. It was not that they did not experience symptoms, but that they experienced a different pattern of symptoms from women in America and Europe. This point was perceived by women in the internet group (Goldstein, 2000), one of whom commented: “there is no equivalent for the ‘stiff shoulder’ syndrome … in Western Societies [sic]. So if we switch to [soy] we may be trading hot flashes for stiff shoulders (Goldstein, 2000, p 321).

Lock pointed out the “powerful symbolic meanings” which attach to menopause and the relationship between menopause and social issues (Lock, 1991). She reports
that “menopausal syndrome” was described in Japan as “a disease of modernity, a luxury disease affecting women with too much time on their hands” (Lock, 1991, p 1272), who were not properly occupied looking after the elderly. It could be argued that this would be a powerful incentive to describe symptoms of age rather than menopause. Alternatively, of course, it may indeed be the case that the diet of Japanese women protects them from hot flushes, and tests using soy supplements to improve menopausal women’s health are continuing (Kritz-Silverstein et al., 2003). The evidence, however, is not conclusive at this stage.

Despite the large body of cross-cultural research, there is not yet enough evidence to confirm reliably the relationship between particular sociocultural factors and the presence or absence of menopausal symptoms. A level of complexity is added by the fact that a number of influential studies seem to have been undertaken by researchers who are not native to the culture being studied, for example, (presumably) Lock (1998) in Japan, and Beyene (1986) in Greece and Mexico. Some writers note the confusing results in cross-cultural research, and warn that “there are enormous differences in the experience of menopause among women in the same culture and among cultures,” and that “we cannot make assumptions of how other cultures treat women and what status they are accorded based on our Western perspective. The key may not be whether women are better treated in other cultures but, rather, how individual women in that culture evaluate their lives at midlife” (Robinson, 1996, p 457).

There is a strand in cross-cultural writing that seems to reflect a yearning for earlier or simpler times (Beyene, 1986; Chirawatkul & Manderson, 1994). A similar trend can be seen in some strands of writing within the feminist model (Taylor & Sumrall, 1991). This somewhat romantic, and even condescending, view that what was traditional is more valuable is debatable. The traditional is certainly valuable and a key
concern particularly for threatened or minority indigenous populations, such as Aboriginal people in Australia and indigenous Americans. If, however, in the situation reported in Thailand by Chirawatkul (1994) for example, women had the choice to freely use contraception, and had access to less onerous ways of dealing with menstruation, as women in industrialised countries do, they may very well prefer to leave traditional practice behind, and their meanings of menopause might be different.

In summary, research undertaken from within the sociocultural model draws on cross-cultural research in an attempt to identify the roles played by cultural context, social role, or lifestage in women’s experience of menopause. This research is not conclusive on these points, although the evidence appears to support the possibility that the symptomatology of menopause varies across cultures (Ryan, Mid-Link Menopause Service, 1999).

2.3.3 The Feminist Model

The models described above are made more complex by their interaction with some aspects of the feminist research model (O'Kane, 1998), and what can be characterised as a “green” model, or an analysis based on what is seen as natural or environmentally sound.

There are multiple meanings of menopause reflected in feminist analyses. Some meanings reflect straightforward biological accounts, but with a proviso that “what symptoms women experience and how severe they are vary from woman to woman” (Ashcraft, 1998, p 73). Some works aim to provide women with a comprehensive account of menopause, including strategies for coping (Doress, Siegal, & Boston Women's Health Book Collective, 1987), and discussions of myths as well as biology (Weideger, 1977). Bleier (1986) explored the relationship between feminism and scientific research, noting that “conducting research on subjects of primary interest to
women, such as menopause” (p 175) was a necessary stage in the development of science that was of equal value to women and men.

Many feminists reframed the discourse about menopause to focus on whole women rather than on their symptoms, balancing what they saw as negative medical descriptions, by the production of positive accounts of menopause (Anike & Ariel, 1987; Bell, 1990; Ferguson & Parry, 1998; Friedan, 1994; Greer, 1991; Le Guin, 1991; MacPherson, 1995; Reitz, 1991). Steinem (1994) has drawn attention to the popularity of the books by Greer (1991), Friedan (1994), and “Ourselves Growing Older” from the Boston Women's Health Book Collective (Doress et al., 1987), citing this popularity as evidence of the women’s interest in a previously hidden topic. In Germaine Greer’s widely publicised book “The Change: Women, Ageing and the Menopause” (1991), Greer pursued the idea that ageing women should reclaim the notion of being crones and witches, and argued that women should resist the medical model, contrasting ‘traditional’ practices with the practices of the “Masters in Menopause” (p 13), a version of the romantic approach discussed above.

The cross-cultural studies by Beyene of Mayan women (Beyene, 1986), by Flint of Rajput women (Flint, 1975), by George of Canadian Sikh women (George, 1988), and by Lock of Japanese women (Lock, 1986) are frequently cited as evidence that women need not experience the physiological and psychological symptoms of which Western women commonly complain (Higgins, 1994), although Lock’s warnings about generalisations are sometimes heeded (Higgins, 1994).

There have been attempts to re-evaluate symptoms such as hot flushes, claiming them as a more positive manifestation by the use of terms such as ‘power surges’ (Sheehy, 1995). Feminists have also used a “metaphor of menopause as transformation” (MacPherson, 1995, p 347), speaking of “the possibility that menopause enhances women’s sense of identity, autonomy, and new psychological strength” (p 348).
Menopause has been claimed as a rite of passage, relying on traditional practices, such as those of Native Americans, for inspiration (Starck 1993, cited in Chornesky, 1998). There has been a search for a “re-vision of mythological portrayals of older women” (Mantecon, 1993, p 77), and attempts to “liberate interpretations of women from an exclusive focus on their reproductive roles” (Gergen, M., 1990, p 471). The evolutionary adaptiveness of menopause has been asserted as a rationale for an anti-interventionist stance towards menopause (Woods, 1998).

In Simone de Beavoir’s (1972) work entitled “Old Age,” the biology of menopause is dismissed in three sentences, with a reference to “the abrupt termination of the ovarian cycle” (p 33). de Beauvoir, however, captures and illustrates themes in relation to aging that still resonate with menopausal women; themes such as the loss of beauty, male disparagement of older women, and despite (or because of) this, the liberation that age can bring to women. While not dealing directly with menopause, it could be argued that by examining aging, a key meaning of menopause (Ballard, Kuh, & Wadsworth, 2001; Foster & Viney, 2001), de Beauvoir violated an even stronger taboo than that directly attached to menopause, opening for discussion an area that has become increasingly important as longevity has increased in the succeeding decades. More recently, in a chapter titled “Doing Sixty,” Gloria Steinem has written of the “new freedom to be ourselves” (1994, p 250) which the postmenopausal women can experience.

There is an interesting shift in feminist concerns as the “second wave” feminists’ age. In the 1970s motherhood (Chodorow, 1978), housework (Oakley, 1974), and the economic and political status of women (Mitchell, 1971; Rowbotham, 1973) were key concerns. It is interesting, however, that in the 1970s, Weideger (1977) had suggested that there may need to be a separate feminist movement for older women. In more recent years, menopause has been debated, as noted earlier, and the
meaning of aging is being claimed for reconstruction (Gergen, M., 1989; Hillyer, 1998; Malone, 1998; Martz, 1987/1993, 1992; Older Women’s Network, 1998, 1999). Hillyer (1998) warned that women must be cautious, as “our writings about menopause and premenstrual syndrome has been used against us, as have any other statements that could be interpreted to imply weakness” (p 57). She suggested, however, that women need to continue to speak with each other, particularly in the context of ageing, to raise awareness of this important time of life. Kaveny (1998) has argued that “the most pressing issue at the intersection of feminism and social justice may be the health status of elderly women” (p 1).

Feminists have pointed out that “many opportunities for studying positive functions of menopause are lost by researchers trapped in a reductionist struggle supported by the menopause industry” (MacPherson, 1995, p 348). Another scholar has drawn attention to what Foucault called ‘the pastoral aspect of medical power’ (Foucault, 1982, p 214) in relation to menopause. That is, the extension of what is healthy to the whole lifestyle, so that all aspects of a woman’s life are medically managed or subject to advice (Sybylla, 1990).

Harding (1986), long ago made the methodological point that:

“the tendency in feminism proposes that a continuum of moral, political, and historical self-consciousness is of primary importance in assessing the adequacy of research practices … A maximally objective science, natural or social, will be one that includes a self-conscious and critical examination of the relationship between the social experience of its creators and the kinds of cognitive structures favored in its inquiry” (p 250).

Feminists, in other words, should move beyond “the social sciences’ relentless but unsuccessful attempts to duplicate the ontologies of the natural sciences” (Goodnow, 1985, p 232), and produce alternative, and more sophisticated accounts of
women’s experience. The feminist analyses were valuable in opening up the debates around menopause, as “it was feminist critics who first argued against the medicalisation of menopause and promoted the concept of menopause as a social construction” (Guillemin, 2000, p 200). Inevitably, later writers argued that ultimately the first generation of analyses were limited.

Wilson (1999) maintains that feminist writers seem to have had difficulty in conceptualizing the biology of the body in a way other than as the embodiment of culture, history and language, and “a site of concern for feminist politics” (Wilson, 1999, p 8). She calls for “sustained, careful, and inquisitive … commentary on scientific and technological matters” (p 9), claiming that “feminisms of all kinds have tended to be disconnected from, or aggressively positioned against, scientific endeavours on the body” and that “such critiques are rarely grafted from informed or intimate encounters with scientific knowledge and methodologies” (p 16). She contends that feminist debates about female bodies have “followed the old familiar refusals of biological detail” (p 8), giving as an example the absence of neurological data from analyses of ‘the anxious body’.

This view does not reflect the full spectrum of feminist endeavour, as writers such as Harding (1986), for example, were explicitly addressing the issue in the 1980s, for example, in her book The Science Question in Feminism. There is, however, a point to be made. It is true that feminist writing has been generated predominantly from disciplines such as history, cultural studies, literature, anthropology, the areas where women are employed. There is, therefore, a lack of balance in feminist accounts of menopause. Guillemin (2000), for example, argues that feminist accounts of menopause have sometimes failed to take account of the fact that “many women experiencing severe menopausal problems have welcomed the exploration of menopause as a biological phenomenon and the development of physiological remedies
associated with menopause” (Guillemin, 2000, p 200). It is interesting that the women in the internet group that I referred to in Section 2.3.1, objected to the “natural process approach” (Goldstein, 2000, p 320). According to Goldstein, “women in the group feel that by emphasising the natural and unproblematic nature of menopause, feminist researchers have silenced the voices of women who are in need of medical attention” (Goldstein, 2000, p 320).

The larger point is important. Dichotomies such as nature or nurture, culture or biology, theoretical analysis or scientific enquiry, have been long superseded as lacking explanatory power in a post-modern context. A non-dichotomous view that can encompass a multitude of perspectives is exactly the sort of endeavour that an interdisciplinary area of research such as feminism, could aim to embrace. Current feminist researchers, such as Guillemin call for analyses that “explore the relationship between women’s biological bodies, social concerns and the role of technologies in these relations” (p 200).

Writers working within the feminist model use multiple meanings of menopause, ranging from biological accounts, to those drawing on myths. Recent feminist researchers, have seen the potential for feminism, as an interdisciplinary area of study, to act as a framework for exploration of the relationship between the varied areas of menopause research.

2.3.4 The “Green” or “Natural Life” Model

I am choosing to discuss separately the green model of menopause, although it is reflected in each of the other models discussed previously. I am characterising as “green” the strand of thought concerned with the natural life, or ecologically sustainable life. The green discourse about menopause has been developed in opposition to the medical model. It is a discourse that is based on a belief about what is natural and its importance for health and well-being. As a sustainable and healthy
future is debated, it is a powerful discourse in industrialised societies. Information produced from the perspective of the medical model has been adapted, and references to menopause being a natural part of life are now incorporated into medical literature, as noted earlier in the discussion of definitions. In an interesting, although limited, analysis of popular literature on menopause in the 1990s, Lyons and Griffin (2003) reported their analysis of four diverse self-help books on menopause and hormone replacement therapy, published between 1992 and 1996, and available in England. They found that “menopause was constructed as a ‘deficiency disease’ in all four texts, although in three of the texts this ‘disease discourse’ was counterposed by the simultaneous use of a ‘menopause as natural’ discourse” (p 1629).

The green model intersects with the sociocultural model in that cross-cultural research is often used to support the propositions of this discourse. For example, Higgins (1994) in *Menopause, Culture and Biomedicine* discusses folk practices and traditional cultural practices that provide holistic explanations in relation to health and contrasts this with conventional western medical practices. A corollary of the argument is that there is a power in behaving “naturally” that could be harnessed by women if they chose (Angier, 1999). An extreme bio-determinist version of this view can be found in discussions drawing on biological and evolutionary bases, such as that calling for a re-evaluation of the “biorhythm of repeated pregnancies” to avoid loss of the “benefits of its hormones” (Wilbush, 1993, p 157).

In the 1970s there was a strong movement towards the “natural life,” inspired by books such as *Silent Spring* (Carson, 1964). During this decade attempts were made to create new meanings for menstruation and menopause, loosely using accounts of cross-cultural traditional practice, and either drawing on psychological theory, such as Jungian concepts (Shuttle & Redgrove, 1980), or debating psychoanalytic theory (Weideger, 1977). A feminist version of the green model has produced arguments
based on the notion that distinctions can be made between experience that is “natural,” and therefore empowering, as opposed to that which is mediated by medical intervention. Zita (1993), for example, writes of menopause as a ‘natural life transition’ after which the empowerment of crones could take place if male definitions of menopause were changed. There is a continuing critique of the relationship between women’s health and the health care industry by feminists, who argue that modern medicine is less beneficial for women’s health than most women assume (Foster, 1996).

There is wide availability of material devoted to natural approaches to health and medicine published electronically and in print. Taylor (1999), for example, cites the Soy Foods Newsletter; Health Reality Check on Line; Harvard’s Women’s Health Watch; Alternative Medicine Alert; A Clinician’s Guide to Alternative Therapies; Herbs for Health; Journal of Alternative and Complementary Medicine.

This material informs a general movement towards a “healthy” life that has been noted in medical circles (Taylor, 1999). The influence of this model was clearly demonstrated in the 74 interviews of this research, and in the Menopause Workshops I conducted in 2000 and 2001. Many women spoke of their desire to experience menopause naturally. This finding was also demonstrated in another Australian study undertaken in Queensland, which found that “contrary to expectations, most Australian mid-life women view menopause as a natural developmental event” (Turner, 1998, p 41). Groeneveld (1993) also found that women thought “climacteric is a natural process” (p 86). Women who espouse this view often believe that they can use natural preparations to alleviate menopausal symptoms so as to avoid the dangers of hormone replacement therapy use.

There are some disturbing aspects to this belief. In 2001, American researchers found, in a survey of 82 women conducted at a pharmacy, that 71.4% believed that
“natural hormones,” that is, plant derived or not synthesised, had fewer or no risks than
standard hormone replacement therapy, and 69% believed that the natural hormones
had fewer or no side effects (Adams & Cannell, 2001). Unfortunately this is not
necessarily the case. A recent study demonstrated that dong quai and ginseng
stimulated the growth of cancer cells in laboratory conditions (Amato, Christophe, &
Mellon, 2002), and results in relation to phytoestrogens “have been conflicting and
difficult to interpret” (Albertazzi & Purdie, 2002). Despite some evidence that
phytoestrogens may reduce symptoms, “there are no randomised controlled trial data”
in relation to risks such as breast cancer (Prince, 2003). Lack of knowledge about
active ingredients or the minimum effective dose, and a lack of standardisation, confuse
the issue in relation to evaluation of “natural” preparations (Albertazzi & Purdie, 2002).
It seems that there are few incontestable conclusions to be drawn from any sphere of
research about menopause.

In the debate about the natural menopause there are clear echoes of the 1970s
debate about natural childbirth versus medically managed childbirth. Generally
speaking, it is the same generation of women that faced decisions about childbirth in
the 1970s, that is now facing conflicting information about menopause (Woods, 1998).
In Chapter 5, I shall discuss women’s feelings in relation to this debate.

In summary, the green or natural life model encompasses a discourse concerned
with the natural life, and a belief that what is natural is important for health and well-
being. This discourse has become powerful enough that references to menopause as
natural are now being included in the medical literature.

2.3.5 Reflections on the Models of Menopause

Recent publications have shown a more sophisticated understanding of the
menopause debate than can be found in any individual model. Lyons and Griffin
(2003), for example, in their analysis of self-help books, found that menopause was
constructed as inherently complex and confusing, as were women’s bodies. They reported that: “any potential contradiction between the ‘disease’ and ‘natural’ discourses of menopause was smoothed over by the use of the third discourse which we have termed ‘menopause as confusing’” (Lyons & Griffin, 2003, p 1638). Lyons and Griffin make a distinction between representing menopause as a source of anxiety for women, and the presentation of menopause as inherently confusing: “the discourse of confusion [in the self-help books] conflates the representation of menopause as a potential source of anxiety, concern and/or puzzlement for women with the construction of menopause and women’s bodies as complex, mysterious and confusing … The ‘menopause as confusing’ discourse … works to alleviate blame on the medical profession for not having a straightforward account of menopause and particularly HRT” (p 1639). Lupton (cited in Lyons & Griffin, 2003) noted that the more information on HRT that a woman obtains, “the more she is likely to be uncertain and anxious about her decision to use it” (p 1639). In the research that I conducted, women reported that they were anxious and confused by the menopause debate and that they were distressed by unexpected changes to their bodies. This to some extent reflects the distinction made by Lyons and Griffin. It is important to observe, however, that it is clear that the medical profession and health authorities are, to some extent, confused about menopause and appropriate menopausal interventions, particularly in the light of recent research (Prince, 2003).

Feminists have complained that women’s health was an under-researched area (Doress et al., 1987). In the case of menopause, this is no longer true, but commercial interests, competing agendas, and the relatively recent attention paid to menopause, have produced a situation in which there is not sufficient conclusive evidence for health authorities to give definitive advice to women.
Murtaph and Hepworth (2002) have argued that “contemporary primary medical care is not a homogeneous, dominant medicine” (p 14), and that “the use of concepts from the women’s health movement has created change in both the positioning of some general practitioners in terms of greater information provision to women and empowerment and positioning of women as having ‘choices’” (p 14). They contend that “the use of the discourse of prevention by medical practitioners changes the position for women by affording them a ‘choice’ about whether or not to take hormone replacement therapy” (p 2). They argue that this changes the role of the general practitioner to that of an adviser with a duty to inform women patients, who should “use this information, this state of being informed, as the basis for making decisions about her health care at the time of menopause and beyond” (Murtaph & Hepworth, 2002, p 2). They observe, however, that “an ‘ethic of autonomy’ and the ‘offer of choice’ by general practitioners in relation to health care for women at menopause, far from being emancipatory, serves to intensify power relations” (Murtaph & Hepworth, 2002, p 9). As Lyons and Griffin (2003) concluded in their study “responsibility for the ‘management’ of menopause as a chronic condition lay solely with individual women” (p 1629), however women are dependent on the health system to provide them with accurate, and appropriate, advice.

In the end, the choices to be made about menopause must be made by each individual woman. Women are faced with contradictory information (Cousins & Edwards, 2002), such as I have described under the headings of the various models of menopause. As with all such matters, a woman makes her health related decisions, and the consequences are lived out in her body. When medical authorities are not able to agree on the most suitable course of action, however, and when other information, stemming from a natural life, or cross-cultural perspective, appears to contradict medical advice, choice and decision-making can be a distressing burden. It may be true
that the medical discourse has been shaped so that “women must take responsibility for ‘managing’ menopause, and this can only be achieved through gaining more medical knowledge and assistance” (Lyons & Griffin, 2003, p 1640), but it is also true that medical knowledge may not be sufficient to provide women with the advice and opportunity for exploration that they need. The view of menopause that emerges from the models, therefore, is confusing, and troubling for women if they require treatment for distressing changes that they are experiencing.

2.4 Theories of Menopause in Developmental and Abnormal Psychology

Major theories of human development have proposed models of development proceeding in stages (Erikson, 1950/1963; Piaget, 1971). Erikson (1950/1963) included in the “eight ages of man” the stage of generativity versus stagnation relating to adults in midlife, and a final stage of ego integrity versus despair. In the 1970s, theorists such as Levinson (1978), Buhler (1972), and Gould (1975), further developed the concept of life as a series of developmental phases, each with particular problems or issues. Both Erikson (1950/1963) and Levinson (1978) drew from male examples, and acknowledged that women’s experience might be different. Sheehy’s (1977) comment in relation to ‘generativity versus stagnation’, was that generativity was “what women have been doing all along” (p 426). Later writers, such as Gergen (1990), pointed out that developmental theories appear to suggest that only men survive past 40. Degges-White (2001) speculated that “the preponderance of theories built to explain men’s developmental transitions reflects the absence of biological transition points that exist for women, including menarche, childrearing, and menopause” (p 5). Whatever the reason, psychological theory is not rich in models of female development that take account of female events such as menopause.
2.4.1 Psychology of Women, Relevant Women Psychologists and Other Research

There are, as Chodorow (1996) observed, many psychologies of women. In the 1970s there was renewed interest in the psychology of women (Bardwick, 1971; Bardwick, 1980; Miller, 1978; Miller, 1973; Rohrbaugh, 1981). Bardwick (1971), for example, drew attention to the paradox that “almost every woman alive is aware that she is part of some huge problem. Almost every magazine published has devoted large amounts of space to it … yet hardly a sound is heard from the professional literature of psychologists” (p 1). She explored the role that cultural practices play in the creation of femininity and masculinity, looking toward a future “in which men and women will experience … role freedom” (p 218). Later, Bardwick (1980) referred to the 1970s as “the decade of the women’s’ movement” (p 9), calling the movement a “tsunami” (p 26) that prompted reassessments of psychological theories of development. Miller (1978) saw a direct relationship between the two: “it is only because women themselves have begun to change their situation that we can now perceive new ways of understanding women” (p 140). Women such as Gail Sheehy (1977) and Carol Gilligan (1979) drew attention to the failure of existing theories to take account of women’s experience. A failure made more acute given the existence of the work of women such as Karen Horney (1967) and Helene Deutsch (1945).

Horney (1945/1992), writing in the psychoanalytic tradition, propounded the idea that the psychosexual development of women was different from men (Horney, 1967), and that the influence of cultural factors on “our ideas of what constitutes masculinity or femininity was obvious” (Horney, 1945/1992, p 11). Deutsch was a pioneer in writing about the psychological development of women, publishing “The Psychology of Women” in 1945 (Deutsch, 1945). Deutsch’s view of menopause, in the psychoanalytic tradition, was that “woman’s last traumatic experience as a sexual being, the menopause, is under the aegis of an incurable narcissistic wound” (Deutsch,
1924, p 56). “The climacterium is under the sign of a narcissistic mortification that is difficult to overcome” (Deutsch, 1945/1973, p 477). She described menopause as a time when women might experience symptoms of depression resulting from the “irrevocable blow to female narcissism induced by the remobilised castration complex” (Harris, 1990, p 67). Deutsch wrote that “successful psychotherapy in the climacterium is made difficult because usually there is little one can offer to the patient as a substitute for the fantasy gratifications. There is a large element of real fear behind the neurotic anxiety, for reality has actually become poor in prospects and resignation without compensation is often the only solution” (Deutsch, 1945/1973, p 498).

Pauline Bart’s (1971) research into women’s role, was an early example of cross-cultural research in which menopause was considered. Bart found that social status changes were the most important indicators for depression at the time of menopause (Bart, 1971). Therese Benedek (1973), presented a more positive view of menopause, more in accord with a developmental perspective (Harris, 1990). She believed that hormonal imbalance resulted in physiological symptoms, but that they would stimulate a psychological process that would lead to psychologic adaption (Harris, 1990). Importantly, Benedek cited surveys finding that 85% of women pass through the menopausal transition without interrupting their daily routine (Harris, 1990).

Jean Baker Miller’s (1973) view was more traditionally psychoanalytic, with a problem-orientated approach to menopause “psychic and somatic symptoms … [may] explode at the time of the menopause” (Miller, 1973, p 394). She also points to the possible danger of menopause as a time of identity crisis for women, in view of the “fearful effect” of “society’s devaluation of anyone past youth” (Miller, 1973, p 394). In the early 1980s, Joanna Rohrbaugh’s (1981) summary of contemporary psychological research about women, included discussions on menopause and
sexuality, and menopause and depression, presenting a critique of negative views of the effect of menopause.

There were other less direct contributions to menopause studies undertaken in the mid 20th century. Ruth Benedict’s book, Culture and Personality, introduced cultural relativism (Stevens & Gardner, 1982), a legacy that is apparent in cross-cultural menopause research today. Similarly, Margaret Mead’s influence was indirect. Her anthropological research on sex differences influenced work on the psychology of women, providing evidence for a social basis for behaviour. In relation to menopause, she is best known for her term “postmenopausal zest,” and her portrayal of the contribution to be made by women in later life (Mead, 1972).

In 1980 Viney (1980) published “Transitions: The major upheavals most women must face and how they experience them” a book describing her research into “the patterns of women’s experiences of transition or change” (Viney, 1980, p 2). In this book she charted the transitions in women’s lives, starting with the change from primary to high school, and moving through the lifespan to approaching death. Women in midlife were interviewed in relation to “the empty nest.” While many expressed feelings of loneliness, some felt guilty because they did not feel anxious and were “having a ball” (Viney, 1980, p 138).

The view of menopause that emerges from psychological and psychoanalytic literature is largely a negative one, focussing on depression and menopause, and menopause and loss (Deutsch, 1924). The concept of role loss, exemplified by the concept of the empty nest (Chomesky, 1998), has largely been overtaken by demographic changes, with researchers in the late 1980s pointing to “the cluttered nest” (Forsyth & Eddington, 1989), as adult children returned home to live with their parents, a continuing phenomenon, presenting a different set of challenges for women.
There is a longstanding link that has been made between menopause and mental illness, particularly depression, which can be traced at least to the 19th century. The term “involutional melancholia,” invented by Kraepelin (cited in Burt & Hendrick, 1997), for a range of symptoms in menopausal women, including depression, was included as a diagnostic category in the DSM-II as recently as 1968 (Burt & Hendrick, 1997). Checklists of menopausal symptoms have, since the 1950s, included depression (Kaufert et al., 1992). Neugarten and colleagues found in 1963 that 57% of the women they surveyed believed that women became depressed or irritable during menopause (1963). According to Kaufert et al. (1992), however, the link between menopause and depression has survived, despite a lack of strong supporting evidence.

The literature on depression presents a complex picture. It is clear that some women do suffer from depression at the time of the menopause, particularly if they have previously experienced depression (Burt & Hendrick, 1997). Other evidence, however, is contradictory. Kaufert and colleagues undertook a large-scale longitudinal study of women in Canada, in which a measure of depression was included. The results indicated that “natural menopause does not appear to increase the odds that a woman will be, or will become, depressed” (Kaufert et al., 1992, p154), and it might be “the shifts and stresses of family life in a woman’s menopausal years which may trigger her depression” (p 154). Similarly, researchers from the Seattle Midlife Women’s Health Study (Woods, 1997) found that menopausal changes had little explanatory power in relation to depression, but that a stressful life was most influential in accounting for depressed mood.

Danish researchers found that moodiness and fatigue, as well as hot flushes, were significantly linked with a natural menopause (Koster & Davidsen, 1993). Contrary evidence was reported from Norway, where researchers found that the only variable significantly related to menopause was vasomotor complaints (Holte &
Mikkelsen, 1991a). A longitudinal analysis of the link between menopause and depression was conducted as part of the Massachusetts Women's Health Study, with findings of a transitory increase in the prevalence of depression among women who were experiencing the transition to menopause (Avis, Brambilla, McKinlay, & Vass, 1994). Avis and McKinlay (1991) had found earlier, however, that “negative attitudes towards menopause were related to general symptom reporting and depression” (p 65). Other researchers have found that depression and anger significantly predicted menopausal symptomatology, and a significant negative correlation between marital satisfaction and menopausal symptoms (Kurpius, Foley, & Maresh, 2001).

In 2002 researchers continued to suggest that prevalence of depression could be substantially higher in women around menopause. In the city of Eindhoven in the Netherlands all Caucasian women of menopausal age were invited to take part in a study to determine whether depressive symptomatology was related to menopause (Maartens et al., 2002). The researchers reported that menopausal transitions seemed to be related to a high increase of depressive symptomatology, concluding that “the decrease of ovarian estrogen production is a risk factor for depressive symptomatology” (Maartens et al., 2002, p 196).

In terms of mental illness in general, Ballinger found that “sociocultural and family factors are more important in the etiology of mental illness in menopausal women than physiological changes” (Ballinger, 1990, p 773). This finding is similar to that of Dennerstein et al (1994) who found that menopausal status was not related to mood measures or to overall well-being, but that current health status, and psychosocial and lifestyle variables, were significantly related to positive moods, negative moods, and overall well-being. Other researchers have found that “natural menopause is a benign event for the majority of middle-aged healthy women” (Matthews et al., 1990, p 11). Some studies associate “a poor mental health index” with menopausal symptom
reporting finding “significant associations of symptoms with an unfavourable response to the measure of mental health” (O'Connor et al., 1995, p 68). It is unclear, however, whether the mental health problems arose prior to the menopause or in response to menopausal changes.

Issues of loss also continue to be identified as central to women at the time of menopause (McQuaide, 1998a), particularly in relation to loss of youth and fertility (Ren et al., 2000), and changing bodies (Banister, 1999; McQuaide, 1998b). Women’s confusion in midlife has been attributed to “negative societal attitudes about aging women” (Banister, 2000, p 745), and it is interesting that menopause has been identified as a marker for middle age (Bromley, 1974).

Researchers now, however, are identifying additional issues that are central for women, such as identity and power (Stewart & Ostrove, 1998), redefining self and self-care (Banister, 1999), a sense of “coming into their own” (Gersick & Kram, 2002, p 104), the development of “own voice” and a sense of freedom (Degges-White, 2001), a second chance at life (Ren et al., 2000), increased independence and freedom (McQuaide, 1998b), and a time for self-development and enhanced self-esteem (Samselle, Harris, Harlow, & Sowers, 2002). Makat (1998) concluded that menopausal women in the 1990s might have had more positive attitudes than previously found because of the changing nature of the society in which they live. The positive aspect of menopause has been suggested as a useful area for research (Hvas, 2001).

A recent large scale study provided evidence that self-esteem rose gradually throughout adulthood, with a decline in old age, and that this “held across gender, socioeconomic status, ethnicity and nationality” (Robins, Trzesniewski, Tracy, Gosling, & Potter, 2002). It is not possible to ascertain whether this is a recent phenomenon or not, but a rise in self-esteem throughout adulthood might provide women with a basis
for approaching menopause with a more positive attitude than has sometimes been recorded.

The studies cited in this chapter largely concern healthy women in midlife. There is less evidence available in relation to other groups of women. There has been a call for consideration of the needs of women with disabilities who are experiencing menopause (Welner, Simon, & Welner, 2002), as more women with disabilities are now living to the age of menopause and wanting to remain active members of society (Welner et al., 2002).

It has been established that women who experience premature menopause, defined as occurring before the age of 40, experience the menopause as a shock, perceiving it “as a major epiphany in their lives” (Boughton, 2002), but their experience is not well understood (Boughton, 2002). An as yet unexamined phenomenon is that of the perimenopausal new mother. As women postpone pregnancy to midlife (Baron-Faust, 1998), some women will inevitably experience menopause concurrently with raising small children, potentially a difficult combination. These issues are areas where continuing, or new, research would be useful, so that women, and the professionals researching their experience, could attain a more comprehensive picture of the experience of menopause.

A further area of research which is inadequately explored is that of women’s coping strategies during menopause (Reynolds, 1999). An Australian study called for more research into the strategies used by women who do not wish to take hormone replacement therapy (Phayer, 1998). The researcher found some evidence that “emotion-focused coping and problem-focused coping strategies … assist in reducing symptom types” for women not on hormone replacement therapy (Phayer, 1998, p 56), but that coping methods such as “diet and exercise do not” (Phayer, 1998, p 56), whereas for women using HRT, a modified diet seemed to be beneficial (Phayer, 1998).
Strategies such as “balancing rest and activity and modifying nutritional intake” as adaptive responses to physiological change, have been suggested (Woods, 1998), but not systematically researched.

The issue of well-being during menopause is also under-researched, although some studies have taken this factor into account (Concin, Ulmer, & Hefler, 2002; Dennerstein et al., 1994), and Utian (2002) has developed a measure of quality of life that aims to assess a sense of well-being. Researchers have found that menopausal symptoms “are likely to induce distress and psychological discomfort” (Wiklund, 1998, p 48), and “a reduction of the quality of life” (Ledesert, Ringa, & Breart, 1995, p 113). Wiklund (1998) commented that if more attention were directed to quality of life issues, the emotional and social, as well as the physical, implications of the menopause would be better understood.

2.5 Popular Representations of Menopause

2.5.1 Media Portrayals of Menopausal Women

(Marcus-Newhall, Thompson, & Thomas, 2001) found that “there is a menopausal women stereotype, and it is mostly negative in content” and “differs from the perceptions of women in general” (p 698). McQuaide (1996), argued that “menopause and mid-life are social constructions” (p 133), and that “since the emergence of the women’s movement in the 1970s, alternative imagery has become possible” (p 133). In her view “midlife and menopause can be a time of searching, transformation, and working on developmental tasks. Women are at risk of having their search and transformation shaped by ageist and sexist images” (p 131). McQuaide (1996) cited Apter’s 1995 conclusion that, “the greatest challenge for a woman was integrating the images formed in adolescence of being female with that of a woman in midlife” (p 23).
Shoebridge (1999) investigated 10 years’ output of two daily newspapers and four women’s magazines. “with few exceptions, discourse about menopause drew on and reinforced schemata of ill-health, psychological disturbance, vulnerability, decrepitude, biological determinism and disease management … the limited discourse about menopause in the surveyed media was characterised by strong themes of illness, medical management and fear” (p 475).

McQuaide (1996) cited Logothetis’ 1991 review of medical and popular literature from the ‘60s, 70s and ‘80s, analyzing the imagery of mid-life women, “she found three images of the menopausal woman: as physically deteriorated, psychologically disabled, and socially worthless … despite the changes in popular culture and beliefs about women in recent years, midlife remains mired in negative images” (pp 133/134). She suggested that “mutual aid groups have the potential of providing an opportunity to supportively and collectively critique negative images of aging women” (p 135).

2.5.2 Pharmaceutical Promotional Material

A full analysis of pharmaceutical promotional material cannot be attempted here. I shall, however, briefly note that the influences of alternatives to the medical model are reflected in pharmaceutical promotional material. Pharmaceutical companies obviously have research findings pointing to the importance of a concern with the natural life. For example, the influence of the green, or natural therapy, model is evident in Solvay’s (2002) medical promotional brochure headlined “one HRT comes closer to Mother Nature.” Elements of the green, and even the feminist, models are shown in Herbalcreations’ (2001) advertisement “menopause. It’s not just a physical thing,” which goes on to discuss anxiety and stress, making the point that they are “not just imagined,” but can be alleviated “naturally.”
It was clear from the research that I conducted that many women did not feel that they could control what was happening to them. Pharmaceutical companies have clearly found similar results in their market research. It is common for pharmaceutical promotional material to emphasise control, such as “take control of menopause” (Novartis, 2002), and “remain in control naturally” (Herbalcreations, 2001), a neat combination of the themes of control and natural therapies. Pharmaceutical companies’ promotional material serves to confirm key trends in menopausal literature, which currently include concerns about the importance of natural processes and products, and women’s concerns about feeling anxious, confused, and not in control.

2.5.3 The Menopausal Paradox

Paradoxically, despite a proliferation of books and articles dealing with menopause in the last five years, and a growth in advertisements for menopausal preparations, there are few opportunities for women to develop their construing about menopause. A number of studies have noted the ‘taboos’ that traditionally surrounded discussion of the topic (Doress et al., 1987; Ferguson & Parry, 1998; Formanek, 1990; Zachary, 2002), and writers such as Rowe (1993) have noted the number of women with a public profile who pretend “that for them it does not exist” (p 56).

Despite apparent publicity about menopause and the development of a “menopause market” (Utian, 1997), women in this research project overwhelmingly referred to the lack of opportunities to discuss their experience. These women showed a keen awareness about the implications of their choices, and an awareness that they are likely to live a third of their lives after menopause (Farrell & Westmore, 1993; Rozenberg, Fellemans, Kroll, & Vandromme, 2000), but they reported that opportunities for discussion were limited and restricted to medical contexts.
2.6 Limitations of Current Conceptualisations

The limitations of current conceptualisations have been discussed in relation to each model and theoretical position as they were presented, however there are overriding limitations to be taken into account. Firstly, “the feelings and behaviours of women who find unexpected and unpredictable changes occurring in their everyday lives are rarely described” (Kittell, Mansfield, & Voda, 1998, p 619), and conceptualisations of menopause, and treatment options, must therefore fall short of the needs of these women. Secondly, there is an imbalance in the literature towards biologically focussed conceptualisations and treatments of menopause, and a lack of attention to psychologically based components of care for women experiencing menopause. Further, when psychological factors are taken into account, as Kittell (1998) observed, “women’s attitudes toward menopause are commonly categorised as positive or negative” (p 61) without specifying any changes that may be associated with those attitudes. Thirdly, it is clear that one model or theory cannot account for the multiple meanings of menopause. Spanier (2000) observed that “the diverse experiences of menopause for women in different cultures illustrate the need for biomedicine to take culture, ecology, and economics into account, along with values” (p 807). Despite cultural or other groupings however, women experience menopause uniquely, interpreting the evidence of their own individual bodies. It is basic to a personal construct understanding that each woman’s experience is unique, and that her meanings should be respected in a discussion of appropriate care. It follows that (a) treatment options should be tailored individually, a view that is gaining more support (Col et al., 1999; Genazzani & Gambacciani, 1999; Kaplan et al., 2002; Notelovitz, 2003) and (b) attention must be paid to women’s psychological well-being as a part of her overall treatment.
“A reconfigured health care for women at menopause … would see health care practitioners, public health researchers and policymakers actively engage with women’s meanings and experiences, negotiating health care beyond narrowly physiological parameters of traditional discursive constructions of menopause” (Murtaph & Hepworth, 2003, p 9). In addition, “it would see health policy regarding women’s long-term health take account of power relations, social inequalities and the social and discursive context of health” (Murtaph & Hepworth, 2003, p 9). A more integrated model would allow an interaction between the undoubted benefits of medical science, and the social and cultural awareness of the links between experiences of menopause and other aspects of women’s lives.

2.7 A Personal Construct Perspective

From a personal construct perspective, any attempt to construe people in terms of their symptoms, or social and cultural norms, involves preemptive constructions that limit the usefulness of predictions and outcomes. The name of a problem is “much less important than a description of the phenomenology of the experience for individuals and those to whom they relate” (Brown, 2000, p 304).

It is essential that women’s individual meanings form the basis of any discussion about menopause. The personal construct belief, that individuals formulate their own constructs with which to view the world, provides a framework within which to explore women’s individual meanings of menopause. I argue that this consideration of a range of individual meanings can inform a more integrated model of menopause and menopausal intervention. Such a model can encompass interactions between medical science, the social and cultural aspects of women’s lives and experiences of menopause, and psychological practice. Therapeutic options can be tailored to the needs that women themselves have expressed, rather than being imposed from the perspective that women’s needs are already known.
2.8 Summary

In this chapter I have described a variety of conceptualisations of menopause. I presented medical definitions, an historical perspective, and four models of menopause: the medical model, the sociocultural model, the feminist model, and the green or natural life model. I also discussed theories of menopause in developmental and abnormal psychology, theories of the psychology of women, and given examples of women psychologists’ thinking about issues related to menopause. In addition, I presented a brief outline of popular representations of menopause. I have noted the limitations of current conceptualisations of menopause, and concluded with a personal construct perspective of how menopause should be approached.

In Chapter 3, I describe a personal construct approach to research and intervention, focusing on a personal construct approach to change. This approach is particularly useful in an exploration of the experience of menopause, that is, by definition, a time of change. I discuss constructive alternativism, and some other major concepts of personal construct theory. I also give an account of the cycles of construction and change, and the disorders relevant to these cycles. Finally, I consider change as a goal of intervention, discussing transition and emotion as the context within which to examine constructions of menopause.
CHAPTER 3

THE PERSONAL CONSTRUCT APPROACH TO THE
POTENTIAL FOR CHANGE
In this Chapter I describe a personal construct approach to research and intervention, presenting concepts from the work of George Kelly (1955/1991a; 1955/1991b), and later personal construct clinicians and theorists. My focus is necessarily on a personal construct approach to change. I discuss Kelly’s concepts in relation to three aspects of change integral to personal construct theory: change as a universal principle, the cycles of construction and change, and change as a desired goal of intervention. I present this discussion in the context that menopause, even if construed in a mainly positive way, is a time of change. A personal construct view of transition provides an illuminating context within which to examine constructions of menopause.

3.1 The Centrality of Concepts of Change in Personal Construct Psychology

Kelly (1955/1991b) observed that: “the psychology of personal constructs is designed around the problem of reconstruing life” (p 830). Encapsulated in this statement is an understanding, firstly, that life involves change, and secondly, that we have open to us the possibility of “reconstrual,” or change in how we see, and think about the world. I shall take up these points in Section 3.2. Change is integral to personal construct theory (Salmon, 1970; Viney, 1992). Kelly (1955/1991a; 1955/1991b), in *The Psychology Of Personal Constructs*, describes change at three levels, firstly, as a universal principle, secondly, as a process in which transition takes place as a person responds to the need for change in an existing construct system, and thirdly, as a desired goal of therapy in the case of psychological disorder.

3.2 Change as a Universal Principle: The Person as Scientist

Kelly (1955/1991a) commenced his work with an examination of the “philosophical roots” (p 3) of his theory, building his discussion around questions such as “What kind of universe?” (p 6) and “What is life?” (p 7). Chiari and Nuzzo (2000)
have drawn attention to the temporality inherent in personal construct psychology, and Kelly makes this clear from the beginning of his work. He declares: “the universe is continually changing with respect to itself … time is the one dimension which must always be considered if we are to contemplate change … within our universe something is always going on … it exists by happening” (p 7). He emphasised “life has to be seen in the perspective of time if it is to make any sense at all” (p 8), that is, life involves change. Kelly continued, however, “but life … is more than mere change” (p 8). At this point he introduced the element of choice: “the creative capacity of the living thing to represent the environment, not merely to respond to it” (p 8), drawing the conclusion that, for a “living thing,” a person in this case, “the universe is real, but it is not inexorable unless he chooses to construe it that way” (p 8). Kelly gave the name constructs to what he described as: “transparent patterns or templates which [a person] attempts to fit over the realities of which the world is composed” (p 9), and the name elements to “the things or events which are abstracted by a construct” (p 137). A construct is, therefore, “a representation of the universe” which is then “tested against the reality of that universe” (p 12), and forms a part of a “network of pathways leading in to the future” (p 560). Each construct is dichotomous, and “discriminates between two poles” (p 563), which represent contrasting meanings. Fundamental to Kelly’s approach was his idea of “man-the-scientist” (p 4). By this phrase, Kelly indicated that he believed that everyone engages in “scientist-like” behaviour, in that all people, not just scientists, aim “to predict, and thus control, the course of events” (p 12).

3.2.1 Constructive Alternativism: The Potential for Change

Personal construct theory is, therefore, based on an anti-determinist belief that it is possible for people to change. People have a choice about how they construe the world, and it follows that they have the potential to reconstrue their experiences. The
concept of “constructive alternativism” proposed by Kelly (1955/1991a) is an expression of the philosophy underlying this belief. Kelly (1955/1991a) used the term to describe the philosophical assumption that “there are various ways in which the world is construed” (p 14) and that “there are always some alternative constructions available to choose among in dealing with the world” (p 15). He argued that: “since an absolute construction of the universe is not feasible, we shall have to be content with a series of successive approximations to it … [that] can, in turn, be tested … for their predictive efficiency” (p 150). Thus, as Kelly maintained, “man creates his own ways of seeing the world in which he lives; the world does not create them for him. … each individual man formulates in his own way constructs through which he views the world of events. As a scientist, man seeks to predict, and thus control, the course of events … The constructs which he formulates are intended to aid him in his predictive efforts” (p 12). Kelly reasoned that it followed that: “all of our present interpretations of the universe are subject to revision or replacement” (p 15), a clear statement of his belief in the centrality of change.

It is evident from Kelly’s reference to “a series of successive approximations” to the universe that Kelly’s was not a relativist position. Rather, personal construct psychology is framed in the pragmatic terms of hypothesis-testing and predictive efficiency (Botella, 2003). Kelly proposed that some constructions: “are undoubtedly better than others … because they support more precise and more accurate predictions about more events … It is not a matter of indifference which of a set of alternative constructions one chooses … While there are always alternative constructions available, some of them are definitely poor implements” (1955/1991a, p 15). This theoretical formulation provides the basis of a personal construct approach to therapy.
3.2.2 Construing Change Using Other Major Concepts of the Theory

Kelly elaborated his theory through a *Fundamental Postulate* and a set of 11 Corollaries. The Fundamental Postulate states that: “A person’s processes are psychologically channelised by the ways in which he anticipates events” (1955/1991a, p 46). This view of people as engaging in anticipatory processes in their interaction with the world is central to a personal construct view: “not only is a construct personal, but it is a process that goes on within a person. It thus invariably expresses anticipation” (Kelly, 1955/1991b). Knowledge can therefore be seen as a hypothetical or anticipatory construction (Botella, 2003), and “behaviour presents itself as man’s principal instrument of inquiry” (Kelly, 1970a). Kelly (1955/1991a) uses the term *validation* to describe the implications of the Fundamental Postulate. If a person’s anticipation of a particular event is correct, the anticipation is validated. If it is not correct, the anticipation is invalidated. Kelly points out the distinction between his notion of validation and reinforcement: “validation refers solely to the verification of a prediction, even though what was predicted was something unpleasant” (p 158). The *Construction Corollary*, “a person anticipates events by construing their replications” (p 50), and the *Individuality Corollary*, “persons differ from each other in their constructions of events” (p 55) elaborate the Fundamental Postulate to specify the processes of individual anticipation.

The *Experience Corollary* extends the Fundamental Postulate to specify a process of change: “A person’s construction system varies as he successively construes the replications of events” (Kelly, 1955/1991a). People successively construe events in order to make better predictions, to anticipate the future. It follows that: “a person's reconstruction of life is a process which goes on all the time” (Kelly, 1955/1991a), p 134), and that meaning is “anchored in its antecedents and its consequents [sic]. Thus meaning displays itself to us mainly in the dimension of time” (Kelly, 1970b, p 3).
The theory also, however, described the limitations to change. Whereas the Experience Corollary describes successive variations to a person's construct system, the Modulation Corollary complements this by acknowledging that this capacity is not infinite. It states that: “the variation in a person's construction system is limited by the permeability of the constructs within whose range of convenience the variants lie” (Kelly, 1955/1991a). The permeability of constructs refers to the capacity of a construct to “admit … new elements which are not yet construed within its framework” (p 79). This Corollary describes the limits to a person’s capacity to change, without making a judgment about the “antecedents,” whether personal or social, of the limits to permeability of constructs.

Although Kelly (1955/1991b) described a person’s potential for change, he also made clear that he was not proposing that “invalidation necessarily causes revision of one’s personal construction of life” (p 831), but that “a personal construction system is an organised thing. The failure of one part of it does not necessarily lead immediately to replacement of that part … even an obviously invalid part of the construction system may be preferable to the void of anxiety which might be caused by its elimination altogether” (p 831).

Kelly (1955/1991b) also observed that his assumption in regard to “revision of one's personal construction of life … is carefully expressed in our Organisation, Experience, Modulation, and Fragmentation Corollaries” (p 831). The Organisation Corollary specifies that: “each person characteristically evolves, for his convenience in anticipating events, a construction system embracing ordinal relationships between constructs” (1955/1991a, p 56). The Fragmentation Corollary states that: “a person may successively employ a variety of construction subsystems which are inferentially incompatible with each other” (p 83). In these last Corollaries, Kelly described two
further characteristics of construction systems that are relevant to a person's readiness
to make changes to their system.

3.3 The Cycles of Construction and Change

The cycles of construction also hold an important place in personal construct
theory. Neimeyer (1987) has drawn attention to how “personal construct theory
highlights the capacity of personal systems of meaning to change across time” (p 9),
and Viney (1992) has developed a personal construct model of adult development,
noting that “the initial integration and the continuing reintegration of … (the)
construing of events are crucial to adult development” (p 67).

Kelly’s (1955/1991a; 1955/1991b) view was that the process of construing was
cyclical (Winter, 1992). He described two cycles of construction, the Circumspection-
Preemption-Control (C-P-C) Cycle, and the Creativity Cycle. In a later work (Kelly,
1970b), he added an “experiential cycle” (pp. 19-20), in relation to the Experience
Corollary. This has since been referred to as the Experience Cycle (Fransella & Dalton,
(1990) refer to the cycles as: “the three cycles of change,” and explain that they
overlap to some extent. “The Creativity Cycle accounts for our originality, but our
original thought may well precipitate us into wanting to take action which moves us
into the decision-making (CPC) cycle. These, in turn, can lead us into the cycle of
experience” (p 41).

3.3.1 The Circumspection-Preemption-Control (C-P-C) Cycle

As Kelly (Kelly, 1955/1991a) describes it, “the C-P-C Cycle is a sequence of
construction involving, in succession: circumspection, preemption, and control, and
leading to a choice which precipitates the person into a particular situation” (p 515).
The Circumspection-Preemption-Control Cycle describes a decision-making process
“in which the self is involved” (p 514). In his explanation of the Cycle, Kelly refers to
both preemptive and propositional constructs, and, in his theory, made a distinction between constellatory, preemptive, and propositional constructs. A constellatory construct is exemplified by stereotyped thinking, and fixes the other ways that a situation is construed, for example, “if this is x then it must also be y.” A propositional construct, in contrast, is one that allows a situation to be construed in more than one way, it is “an uncontaminated construction” (Kelly, 1955/1991a). Winter (1992) illustrates this concept with the example of a person experiencing difficulty at work, who is able to construe themselves in a number of other ways, such as a talented musician, not only as a person experiencing failure at work. A preemptive construct, on the other hand, does not allow any other construct to be applied. Kelly (1955/1991b) illustrates this with the example: “if this is a ball it is nothing but a ball” (p 563).

The C-P-C Cycle starts with the process of Circumspection, when a person looks at the elements of a decision “propositionally, or in a multidimensional manner” so that the “propositional construction of oneself opens up the possibility of one's acting in a great variety of ways” (Kelly, 1955/1991a), p 521). The Cycle continues with Preemption, when a person selects the crucial issue and disregards “the relevancy of all the other issues that may be involved” (p 516). Having arrived at a preemptive construction, the final phase of the Cycle is Control: “Control, or the choice of an alternative, is a function of the side of the construct which better permits elaboration” (p 520). Kelly emphasised that “the final ‘C’ in our term might stand for choice as well as for control” (p 516), and this cycle in fact outlines the process of choice.

The concept of choice is critical in Kelly's thinking, and is elaborated in the Choice Corollary, which states that: “a person chooses for himself that alternative in a dichotomised construct through which he anticipates the greater possibility for extension and definition of his system” (p 64). Thus control is the choice of an
alternative which “better permits elaboration” (p 520). Kelly maintained that the Choice Corollary was “crucial” (Kelly, 1969, p 89), explaining that it was “a natural outgrowth of that [Fundamental] postulate” (p 88). The Choice Corollary, and the C-P-C decision-making cycle, are expressions of Kelly's central belief that people have a choice in their courses of action, and so the potential for change. The issue, of whether a person is able to take advantage of this potential, is discussed by Kelly in a chapter on Disorders of Construction, to which I shall refer in Section 3.3.4.

3.3.2 The Creativity Cycle

The Creativity Cycle describes “the way in which a person develops new ideas” (Kelly, 1955/1991a, pp. 514-515), with each phase of the cycle necessary for creativity, the development of new constructions, and action. It is a cycle that, optimally, “starts with loosened construction and terminates with tightened and validated construction” (Kelly, 1955/1991a, p 528). Kelly (1955/1991b) defines loosening as “characteristic of those constructs leading to varying predictions” (p 1030), and describes a loose construct as one which “tends to be elastic, relating itself to its elements only tenuously; yet it retains its identity as a personal construct in the client’s system” (p 1030). He describes a tight construct as holding “its elements firmly in their prescribed contexts” (p 1030), and as “one which leads to unvarying predictions” (p 565).

The loosened construction phase is one in which “the person shows a shifting approach to his problems” (Kelly 1955/1991b, p 529), providing a context for the generation of new ideas (Winter, 1992) and predictions. Kelly (1955/1991b) regarded loosening as “one of the most important procedures” (p 1060) in achieving reconstruction. He described loosening as producing “the shifting of elements in the construct context [which] represents an incipient movement in the construction system. The result is that new experience is produced and new responses are elicited from
one’s associates” (p 1033). Further functions of loosening identified by Kelly (1955/1991b) were that “shifting permits certain elements to come into the field of one’s attention”; “looseness permits some extension of the construct’s range of convenience”; and can make “the construct more permeable to new experience” (p 1033). Loosening can also be used to help in recalling events, shuffling ideas into new combinations, producing a verbal expression of a preverbal construct, and opening up a preemptive construct to new applications (Kelly, 1955/1991b).

Group-work can be particularly useful for facilitating loosening. It is a phase in which a person can become “more open to a wider range of interpretations” of their construing (Viney, 1996, p 105). New experience can result from sharing constructs between group members and revising constructs in the light of responses from the group. Kelly (1955/1991b) described four techniques for achieving loosened construing: relaxation, chain association, reporting dreams, and the therapist’s uncritical acceptance of the client. In a group setting, it is crucial that the last requirement expands to become a commitment by all group members to uncritical acceptance of each other. Personal construct therapists have since documented other loosening strategies (Winter, 1992), such as guided imagery or artistic expression (Neimeyer, 1988c), and noted the significance of issues such as environmental conditions, for example, subdued lighting, and therapist behaviours, such as open posture (Neimeyer, 1988c).

The tightened construction phase involves a “rigid assignment of elements within the construct's context” (1955/1991b) and allows an action possibility, or a precise prediction, to be selected and tested. Kelly (1955/1991b), explained that the “first function of tightening: to define what is predicted” (p 1063), in order to help a person make the world more predictable: “a tightened construct may enable one to make definitive predictions of what is to come” (p 1064). Furthermore, tightening
serves to stabilise construction, so that construing is not confusing for the self and others. It also facilitates organisation of the construct system, by making definitions of subordinate constructions more precise, and therefore allowing a reorganisation of superordinate constructs. Tightening may be used to reduce constructs that are not useful to a state of impermeability. Finally, tightening may serve the function of facilitating experimentation. For a person to move towards action, from the fluid thinking that is characteristic of the loosening phase of the Creativity Cycle, it is necessary to tighten construing to become more stable and explicit, so that words can be found for the new construct, and it can be tested.

Kelly described tightening as a form of elaboration (1955/1991b) and documented a variety of techniques that may be used to achieve tightened construing. These include asking a person to make judgements about his or her previous behaviour, or to summarise thinking in an interview, asking for validating evidence, and using enactment to make constructions explicit. As with loosening, Neimeyer, (1988c), has drawn attention to environmental conditions, and therapist behaviours, as factors in producing tightening. He theorised that environmental factors such as group-work, lack of privacy, bright lighting and upright seats, and therapist behaviour such as forward leaning posture, would create a context for tightened construing.

The C-P-C Cycle can be seen as a process resulting in action, and the Creativity Cycle as a process resulting in new ideas. Kelly (1955/1991a) observed that: “in some respects both cycles are related, since the new act often involves a new construct and one finds himself on the verge of new constructs as a result of his venturesome acts” (p 515). Dunnett (1985) has provided a useful exploration of this idea: “Control is important in relation to creativity in that the purpose of the Creativity Cycle is to provide new constructs with which to construe new events, and such construction is ultimately dependent upon an ability to enact experiments” (p 42) that is, complete the
C-P-C Cycle by achieving control. Kelly (1955/1991b), however, pointed out some important differences between the cycles. Firstly, “in the Creativity Cycle there may be no appreciable personal commitment” (p 1061), that is, it may not relate to a course of action in which a person is actively involved. Secondly, the processes of the Creativity Cycle relate to a single construct, whereas in the C-P-C Cycle, a choice may be made from “an array” (p 1061) of constructs. In an important elaboration, Kelly provided the example of Hamlet’s soliloquy to illustrate the point that a person might be involved in both the cycles at the same time. In Hamlet’s case “vague loose constructs had been taking shape in his mind. … with respect to his father … his mother, and … Ophelia” (p 1061), that is, he could be seen as involved in the loosening phase of the Creativity Cycle. At the same time he was considering courses of action, to be or not to be, in the circumspection phase of the C-P-C Cycle (p 1062), but as Kelly commented, Hamlet completes neither cycle.

3.3.3 The Experience Cycle

In an essay written in 1966 Kelly (1970b) referred to the Experience Corollary, which states that “a person's construct system varies as he successively construes the replication of events” (p 17), explaining that “a succession of … investments and dislodgements [from particular constructions] constitutes the human experience” (p 18). He went on to elaborate: “the unit of experience is, therefore, a cycle embracing five phases: anticipation, investment, encounter, confirmation or disconfirmation, and constructive revision” (p 18). Anticipation is, of course, fundamental to the personal construct view of human processes, as expressed by Kelly’s (1955/1991a) Fundamental Postulate. It is also integral to meaning: “besides including anticipated outcomes, meaning includes also the means by which events are anticipated” (Kelly, 1970b, p 3). After anticipation, investment in the anticipation marks a preemptive
choice of construction, then encounter provides a test of the construct, which is either confirmed or disconfirmed, leading, in an optimal case, to constructive revision.

This cycle is followed by a “subsequent experiential cycle” (Kelly, 1970b, p 19). The conclusion to be drawn from the Experience Corollary, and the explanatory “experiential cycle,” according to Kelly, is that “a man's experience is not measured by the number of events with which he collides, but by the investments he has made in his anticipations and the revisions of his constructions that have followed upon his facing up to consequences” (p 19). Commenting on the Experience Cycle, Fransella and Dalton (1990) noted that at the conclusion of an instance of the cycle “whatever the outcome, there will be some degree of change. The person will never be quite the same again” (p 42). Again, the emphasis is on people’s potential for change as a result of experience. As Dunnett (1985) commented: “we are not ‘victims of our biography’” (p 37).

3.3.4 Disorders of Construction

Failure to complete any of these three cycles of construction results in what Kelly described as disorders of construction. Disorder, in Kelly's theory, is a person’s use of “any personal construction which is used repeatedly in spite of consistent invalidation” (Kelly, 1955/1991b). A disorder “represents any structure which appears to fail to accomplish its purpose” (p 835).

Kelly observes that: “in a sense, all disorders of construction are disorders which involve faulty control” (p 927). In relation to the C-P-C cycle, endless circumspection would preclude action, whereas the preemption of issues is characteristic, Kelly observes, of “the man of action” (p 516). Such a person sees things in an oversimplified manner and acts impulsively, without a full consideration of the implications of action.
In relation to the Creativity Cycle, Kelly argues that some people’s characteristic use of loose or tight construing are also disorders of construction (Kelly, 1955/1991b). He referred to the dimension of “loosened versus tightened construction” as “one of our most important reference axes” (p 1029). A person whose construing is characteristically loose can “never get around to setting up a hypothesis for crucial testing” (p 529). The person’s “inferences … vary from occasion to occasion” (p 853), their constructs are comprehensive, and include a variety of elements. A person whose construing is characteristically tight cannot “produce anything which has not already been blueprinted” (p 529), “every prediction, every anticipation, must be precise and exact … there are no loose fits” (p 849). Although “tightening makes it possible for the action resulting in a C-P-C cycle to take on a clear meaning for the person” (Epting, 1984, p 119), “tightening does not commit one to action. It only creates the possibility for action, in that the construct is restricted to a set of unvarying predictions” (1984, p 119).

The Experience Cycle describes a “total unit of experience” (Epting, 1984, p 55), and disorders of construction may arise at any stage in the cycle. It follows that, in broad terms, “disorders represent a failure to complete the Experience Cycle” (Winter, 1992, p 104).

Some theorists (Walker, 2002; Walker, Oades, Caputi, Stevens, & Crittenden, 2000) have proposed the addition of the concept of nonvalidation to personal construct theory “to refer to instances of noncompletion of the ideal validational process” (p 53), based on the idea that “people sometimes engage in neither validation nor invalidation” (p 49). They propose that construing strategies such as endless circumspection, making loose predictions, and hostility, which I shall discuss in Section 3.3.5, could be seen as types of nonvalidation strategies.
3.3.5 Transition and Emotion

Throughout life, as circumstances change, people are confronted by challenges to their construct systems. While many transitions may be easily accommodated, others are more difficult. Particular transitions may present more of a challenge than others; transitions may be more difficult at some times than others; and some people “have much more difficulty than others in setting up adaptive solutions to their problems” (Kelly, 1955/1991a).

Kelly (1963) claimed that, in his theory, the reader would find “no emotion” (p. xi). Kelly argued against making a distinction between affect and cognition, holding that construing represented the totality of processes involved in psychological differentiation (cited in Sewell, 1995). Nevertheless, emotions do play a part in Kelly’s work (Winter, 1992), but they are defined as diagnostic constructs, and “assigned restricted meanings” (Kelly, 1955/1991a). In The Psychology Of Personal Constructs Kelly (1955/1991a; 1955/1991b) described the set of diagnostic constructs that are relevant to transition. These are threat, guilt, fear, and anxiety. Kelly provided specific definitions for these terms that restrict but, as he was at pains to point out, do not abrogate, their common meanings (Kelly, 1955/1991a). Threat is defined as “the awareness of imminent comprehensive change in one’s core structures”; fear as an awareness that “a new incidental construct, rather than a comprehensive construct, … seems about to takeover”; anxiety as “the recognition that the events with which one is confronted lie outside the range of convenience of one's construct system”; and guilt as the “perception of one's apparent dislodgement from his core role structure” (Kelly, 1955/1991a).

Of these emotions, it is anxiety that is the focus of this work. It is important to note Kelly’s comment that: “anxiety, per se, is not to be classified as either good or bad. It represents … a precondition for making revisions” (p. 498). The extent of
anxiety will depend on what portion of the construct system has been put at risk by invalidated predictions. Anxiety is, therefore, a “harbinger of change” (p 836). Kelly (1955/1991b) observed that: “whereas a ‘‘normal’ person … lives with anxiety” (p 896) and “anxiety is universal among mankind” (p 900), there is a sense in which all disorders of construction are disorders involving anxiety” (p 895). Fransella (1993) has noted that “anxiety certainly accompanies all change, for we never quite know if we have got it right until we conduct that essential behavioural experiment. But, for some, the anxiety is global since it involves changing one's self” (p 124). It may also be experienced if “the implications of change are, for some reason, outside the range of the person's construing” (Dalton, 1993, p 110), or if a person is anxious in relation to “situations which are expected to arise in the future” (Kelly, 1955/1991b). The need for change, therefore, will generally be signalled by anxiety: “Invalidating evidence will normally lead to the abandonment of constructs, to anxiety, and thence to revision” (Kelly, 1955/1991a).

Kelly (1955/1991b) viewed depression, also central to my work, as associated with attempts to constrict the system. Kelly illustrated this with the example of a depressed client who was hospitalised, which helped to constrict his field, resulting in diminished anxiety. Kelly also observed that “constrictive weeping,” that is, a withdrawal into weeping is typical of “‘depressed’ cases” (p 1116). Anxiety is an expression of a lack of adequate structure in the construct system, but depression constricts the system, and reduces anxiety, so the revision of constructs is postponed. Aggressiveness on the other hand, was defined by Kelly as “the active elaboration of one’s perceptual field” (p 508). A person might, therefore, be “particularly aggressive in the area of his anxiety” (p 509), testing constructs in order to develop the structure to deal with new experiences.
Kelly was principally writing about psychotherapy, and the indications, and treatment, of people's distress, exemplified by his definitions of behaviours such as anxiety. McCoy (1981) has since proposed definitions for a range of positive, as well as negative, emotions in personal construct terms, covering, for example, positive feelings that might occur if a transition were successfully completed. McCoy’s context was that “consistent with Kelly’s construction … emotion behaviours are seen as indicators of the state of one’s construct system following awareness of a need to construe. Emotions are signals of the, otherwise, difficult to observe construing process” (p 96). McCoy’s view was that “positive emotions are those which follow validation of construing. Negative emotions follow unsuccessful construing” (p 97). Viney (1990) also argued that: “negative feelings, in general, occur when people's construct systems do not permit effective interpretations and anticipations so that they experience invalidation” (p 210). McCoy included in her list positive emotions such as love, happiness, self-confidence, and contentment. Self-confidence, for example, is defined as: “awareness of the goodness of fit of the self in one’s core role structure” (p 97), and contentment is defined as “awareness that the events with which one is confronted lie within the range of convenience of the construct system” (p 97). Importantly, McCoy noted that: “it is not the outcome of the prediction … which is the emotion … but an awareness of the state one is in as a result of the fate of the construction which was involved in the prediction” (p 97).

Viney (1983; 1986) and Westbrook (1976; 1980) have documented the means of assessment of positive as well as negative feelings within a personal construct context. The Positive Affect Scale (Westbrook, 1976), for example, might be used as an indication of positive feelings that would occur after a transition is complete.

The disorders of transition, as Kelly (1955/1991a) identified them, involve hostility, constriction, dependency, and anxiety. The last emotion has been discussed
above. Hostility was defined by Kelly as: “the continued effort to extort validational evidence in favour of a type of social prediction that has already proved itself a failure” (p. 510), or trying to “alter the events in an effort to make them conform to … original expectations” (p 511). A person uses a hostile strategy to avoid reconstruction, because, “hostility represents inability to cope with the outcomes of one's social experimentation” (Kelly, 1955/1991b). Kelly also defined hostility as a state that “carries with it the implication that the mess in which one finds himself is of his own making. The discomfiture one feels is a form of anxiety” (Kelly, 1955/1991b) p 879). According to Kelly hostility has four features: firstly, an intolerable, chaotic situation, “fraught with anxiety” (p 884), which, secondly, is perceived by the person as “an outcome of his own social experimentation” (p 884); thirdly, “the hostile person seeks appeasement rather than understanding” (p 884) and fourthly, “hostility may sometimes be alleviated … by aggressive exploration” (p 884). Kelly observed that: “the hostile person always hopes to prove that he was right in the first place” (p 883).

The dilation or constriction of a person's perceptual field is an important dimension of construing. Dilation “occurs when a person broadens his perceptual field in order to reorganize it on a more comprehensive level” (Kelly, 1955/1991b). It describes a strategy of accommodating incompatibilities in construing (Winter, 1992) by, for example, increasing the permeability of some constructs, that is, the construct “admits newly perceived elements to its context” (Kelly, 1955/1991b), or by loose constructions. Constriction involves a person limiting the events to which she attends. It can occur when choice seems impossible but some action appears necessary (Dunnett, 1985). Dunnett found that “the process of constriction may take the place of both the circumspection and preemption phases of the [C-P-C] cycle” (p 42). A person may constrict their system until only one possible choice remains, a form of control that avoids reconstruction of superordinate structure. Interestingly, Kelly
(1955/1991b) uses the example of menopause to illustrate a case in which a person experiencing irregular and unpredictable bodily processes might use constriction in the face of confusion and anxiety. He notes that constriction does not produce a permanent solution, as it does not help establish new, more useful, constructions.

Kelly (1955/1991b) stated that while dependency was not “one of the principal axes in our diagnostic construct system” (p 913), it was “treated more like a phenomenon” (p 913). He added, “from the viewpoint of the psychology of personal constructs, dependency is something that everyone has” (p 868), as “adults are highly dependent upon a complex society made up of many people” (p 913). Ideally, however, an adult “discriminates between his dependencies and then disperses them appropriately” (p 914). Disorders in this area arise when people “do not disperse their dependencies in a discriminative fashion” (p 914).

As with other professional constructs developed by Kelly the diagnostic constructs that he used are, in themselves, free of positive or negative connotations. Construing characterised by these dimensions may be helpful or may create a problem (Fransella & Dalton, 1990) depending on the context. The specification of disorders of construction or transitions carries, in each case, its own therapeutic implications, that point to the need to assist clients to achieve an effective change in construing. Kelly’s theory gives personal construct psychologists a future-oriented perspective from which to view clinical practice. A belief in the possibility of individual change is inherent in the assumption of constructive alternativism. This important concept, which Kelly (1955/1991a) assumed “underlies our theory” (p 3) is, in essence, the liberating theoretical basis for a personal construct approach to working towards helpful change. It allows an optimistic view of a client’s potential for change, and provides a goal for interventions: that of assisting clients to form new constructions, “reconstruing life” (Kelly, 1955/1991b), and make choices with more useful predictive power, “to
alleviate complaints” (p 831). As elaborated in the Choice Corollary, a personal construct approach to psychotherapy is built on the notion that choice, both of meanings and actions, is possible. “The theme that we are not ‘victims of our biography’, that we can choose which direction we take in our lives places great emphasis on this process of choice and the way we make our decisions” [italics in original] (Dunnett, 1985, p 37).

3.4 Change as a Goal of Intervention

Kelly (1955/1991a) developed his theory with a range of convenience, he noted, restricted “to human personality and, more particularly, to problems of interpersonal relationships” (p 11). He specified that his theory “tends to have its focus of convenience in the area of human readjustment to stress” (p 12). According to Kelly (1955/1991b), “the goal of psychotherapy is to alleviate complaints - complaints of a person about himself and others and complaints of others about him” (p 831), and the “basic task of the psychotherapist [is] elaboration of the construct system in which his client’s difficulties are anchored” (p 976). He specified the elaboration of the construct system, rather than the complaint, because this, he believed, placed the emphasis on “see[ing] alternatives” (p 977). Kelly saw the clinician’s role as “fundamentally one of helping the client to revise constructs” [italics in original] (p 586), in order to “find suitable reconstructions for the future” (p 1091). The possibility of movement, change and reconstruction are emphasised in personal construct theory. Kelly argued that “the movement and release of ongoing developmental processes resulting from successful psychotherapy are presumed to be accomplished by means of the revised conceptualisation of the whole course of one’s life” (p 566).

3.4.1 Transitive Diagnosis

Kelly’s (1955/1991b) use of the term transitive diagnosis is a further reflection of his emphasis on change and movement. He said “the term suggests that we are
concerned with transitions in the client’s life, that we are looking for bridges between
the client’s present and his future” (p 775). Kelly lamented the tendency to “impose
preemptive constructions upon human behaviour” (p 775) in the name of diagnosis. He
argued: “the client does not ordinarily sit cooped up in a nosological pigeonhole; he
proceeds along his way. If the psychologist expects to help him he must get off his
chair and start moving along with him” (p 775). Johnson’s (2000) view is that “Kelly's
attention was clearly drawn to the process of change, so it was natural that he might
formulate a diagnostic system with a similar emphasis” (p 153). Personal construct
theory places “the principle of change firmly within the person” (Salmon, 1970, p
203), as “psychological change involves changes in personal meanings, which are
relationships among patterns of activity” (Mahoney, 2000, p 46). “Personal constructs
are pointed towards the future,” as Epting and Prichard have observed (1993, p 56).
This belief in a person’s capacity for change allows the “construction of new worlds”
(Gergen, 1992), or “opening of new alternatives for thought and action, both socially
and individually” (Botella, 2003, p 18). Chiari and Nuzzo (Chiari & Nuzzo, 2000)
made the aim of intervention clear: “a personal change is exactly what psychotherapy
strives to favour” (p 97). This change develops from an awareness of an expanded
choice of meanings, providing new choices of action.

3.4.2 Responses to the Need for Change

A person may vary in her response to the need for change. As Winter has
explained: “from the personal construct theory perspective, it is, of course, to be
expected that individuals should differ in the nature of their response to an experience
such as therapy. Thus, therapy would be expected to lead to reconstruction only if it
offers the client the possibility of further extension or definition of his or her construct
system, and if it does not confront the client with too high a degree of such negative
emotions as anxiety, threat, and guilt” (Winter, 1992, p 160).
Social issues were important to Kelly (1955/1991a; 1955/1991b), and the concept of role played an important part in his theory. He described a role as: “an ongoing pattern of behaviour that follows from a person's understanding of how the others who are associated with him in his task think” (p 97). Kelly discussed two different strategies a person might adopt if something “has gone wrong with his anticipation system ...(and) there are too many rude surprises. It becomes apparent that he must do something about his role. The most obvious thing to do is to start reclassifying his role within the contexts of some of his personal role constructs” (p 134). As a person reconstrues himself, however, he “may either rattle around in (his) old slots or (he) may construct new pathways across areas which were not previously accessible” (p 128), to arrive at new choices of meanings and action.

The tension between the need for change and a person's capacity to develop new constructions is, of course, the ground upon which interventions are based. As Bannister (1977) observed: “while a person’s interpretation of himself and his world is probably constantly changing, to some degree, there are times when his experience of varying validational fortunes make change or resistance to change a matter of major concern” (p 27). Fransella (1993) took up the concept of resistance to change, identifying two types of change: one occurring within a system, in which a person reconstrues within relatively subordinate construct systems, and the other occurring to change the system itself, in which a person develops new constructs at a superordinate level. She argued that when therapists experience resistance from clients, it comes “when the client is changing within the system” [italics in original](p 120), and that this change “may well be a vital preparation for the change we are hoping to see - the change in the system” (p 120). Other theorists have explored factors relevant to a person’s capacity to change beliefs, identifying factors such as personal exploration as important in this (Neimeyer, MacNair, Metzler, Courchaine, 1991).
Mahoney (2000) has also observed that “disorganisation is essential to ongoing reorganisation … resistance to change is greatest when core ordering processes are challenged, and acute episodes of turbulence shake the very heart of the system” (p 45). Clients are more likely to change their self-construing if the target constructs carry few implications and “occupy a subordinate position in their construct hierarchies” (Winter, 1992, p 162). As Mahoney (2000) noted “resistance to change, even desired change, is common, especially when the change is experienced as ‘too much’ or ‘too quickly’” (2000, p 46). Neimeyer (1987) suggested that it is useful at the beginning of therapy for therapists to ask themselves whether there are any “superordinate constructs in the client’s system that are too rigid to permit change” (p 9). As Kelly (1955/1991b) observed, “the revision of constructs is not always easy to accomplish” (p 847).

Personal construct psychotherapy encompasses a variety of approaches to therapeutic change, designed in response to specific difficulties in construing or construction systems (Neimeyer & Raskin, 2000; Winter, 1992), such as those described in Section 3.3.4. I shall discuss personal construct approaches to interventions in more detail in Chapter 6. Kelly (1955/1991b) said, in relation to diagnosis, that “diagnostic dimensions are avenues of movement as seen by the therapist, just as the client’s personal constructs are potential avenues of movement as seen by the client” (p 775). This is the clearest possible indication of the way concepts of movement and change are integral to the personal construct perspective.

3.5 A Summary of the Important Concepts of Change

A personal construct approach, rich in theorisations of change, is particularly useful in an exploration of the experience of menopause, that is, by definition, a time of change. The important personal construct concepts that I have discussed in this chapter include those related to a person’s potential for anticipating and reconstruing
the world, expressed in the assumption of Constructive Alternativism, Kelly’s (1955/1991a) Fundamental Postulate, the concepts of validation and invalidation, which describe the implications of the Fundamental Postulate, and Kelly’s conception of the person as scientist. I have also summarised the limits to change described in personal construct theory, such as in the Modulation Corollary, and the concepts of the impermeability or permeability of constructs. I have discussed the cycles of change: the Circumspection-Preemption-Control Cycle of decision-making, the Creativity Cycle of loosening and tightening of constructions, and the five-phase Experience Cycle. I have also presented other concepts such as transitive diagnosis, the diagnostic constructs associated with transition, such as anxiety, and the disorders of transition, such as hostility, constriction, and dependency. Finally, I summarised responses to the need for change, including a brief outline of the concept of role.

In the next chapter, I shall build on the personal construct framework that I have presented, to explore a personal construct approach to menopause. I describe aspects of construing that are important to a personal construct understanding of the menopausal transition. Next, I present a personal construct model of menopause, describing two overarching meanings of menopause, four construing patterns linked with menopause, and a fifth construing pattern relating to an intervention for women experiencing, or anticipating, menopause. Finally, I outline the themes that are related to the patterns of construing in the model.
CHAPTER 4

A PERSONAL CONSTRUCT MODEL OF MENOPAUSE
In this Chapter, I present a model of menopause developed on the basis of personal construct theory. Firstly I briefly describe features of the work and social contexts that provide the setting for women’s experience of menopause as it is documented in this research. I then move to a consideration of menopause from a personal construct perspective, and describe aspects of construing that are important to a personal construct understanding of menopause. Next, I present a personal construct model of menopause, which includes two overarching meanings of menopause, four construing patterns linked with menopause, and a fifth construing pattern consistent with the desired outcome of an intervention for women experiencing, or anticipating, menopause. Finally, I identify the themes that are related to the patterns of construing in the model.

4.1 The Contexts for the Model

This research has been conducted in relation to the social, and work, context in developed countries. From a personal construct perspective, this context presents many challenges for women construing themselves in relation to menopause. Some women deal with these challenges effectively, and successfully reconstrue themselves. Others simply do not construe the changes of menopause as significant. Other women experience difficulty as they try to negotiate the menopausal transition to reconstrue themselves. Two specific contextual factors are relevant: the work context and the social context.

4.1.1 The Work Context

Whilst the changes in women’s reproductive status may have an impact on their physical, mental and emotional well-being, child-bearing is the only state that is recognised as requiring regulation in the work-place. This is a difficult area. The debate about whether women’s reproductive status should be a factor in excluding them from certain occupations and activities is relatively recent. In countries such as
Australia, the United States, and Britain, anti-discrimination, and equal opportunity, legislation bars discrimination on sex-based grounds, including pregnancy. Women are nonetheless dismissed, denied promotion, or chosen for retrenchment ahead of other employees, on the basis of their pregnancy (Equal Opportunities Commission, 2003b; Law Reform Commission, 1999; U.S. Equal Employment Opportunity Commission, 2003; Workplacelaw Network, 2003).

This history leaves women in a difficult position during menopause. On the one hand, for some women the physical changes may be distressing and affect their well-being. Menopausal symptoms may, for example, result in a chronic lack of sleep. The attendant tiredness clearly has the potential to affect many areas of a woman’s life, including work. On the other hand, women still do not have parity with men in terms of level of income or level of occupation (Equal Opportunities Commission, 2003a; New South Wales Anti-Discrimination Board, 2003; U.S. Equal Employment Opportunity Commission, 2000). The existence of cases relating to pregnancy brought to equal opportunity bodies (Equal Opportunities Commission, 2003b; Law Reform Commission, 1999; U.S. Equal Employment Opportunity Commission, 2003; Workplacelaw Network, 2003) is evidence that workplaces may still be reluctant to make proper provision for women when pregnant. Women would be risking a new raft of exclusions if they drew attention to the type of difficulties that menopause (or menstruation) present for some women. The notion of reasonable adjustment seems out of the question at this time. In the current situation, it is in women’s interest to manage the changes of menopause in such a way that they do not appear to interfere with working life. From a psychological point of view, this strategy has its own risks for women’s wellbeing.
4.1.2 The Social Context

Currently, in western society, there is a general movement towards a “healthy” life, which is allied to an interest in the “natural” in relation to health issues (Taylor, 1999). Women who construe menopausal changes as natural, may also, if they experience distressing symptoms, construe themselves as a failure as a “natural” woman. There are parallels with women’s expectations of themselves in childbirth. The growth of the natural childbirth movement in the 1970s (Kitzinger, 1962/1972), was accompanied by authors claiming, for example, that “approximately 95% of deliveries - even in modern society - require little or no technical assistance other than catching the baby and tying the umbilical cord” (Brack, 1979, p 86). This type of advice placed pressure on women to try to give birth “naturally,” and could lead to women feeling a sense of failure if it was not achieved, a scenario still evident in popular accounts of childbirth today (Freedman, 2003).

Secondly, despite the apparent availability of information on menopause, women report a lack of opportunities for discussion of their experience of menopause, outside medical contexts. This social context, like the work context, may make the menopausal transition more difficult for women. Women may have difficulty in developing elaborated constructs about their menopausal experience and moving to reconstruction.

4.2 Menopause from a Personal Construct Perspective

In Chapter 3, I described a personal construct approach to change. I gave a brief outline of constructive alternativism, the assumption that people have a choice about how they construe the world. I gave an account of Kelly's (1955/1991a) Fundamental Postulate, and the terms validation and invalidation which describe the implications of the Fundamental Postulate, or the outcomes of a person's anticipation of an event. I referred to the person as scientist, the concept that each individual formulates constructs
through which to view, predict, and try to control, the course of events. I also
summarised the corollaries propounded by Kelly (1955/1991a), such as the Experience
Corollary, which describes successive variations to a person's construct system. I
described the limits to change described by the Modulation Corollary, which refers to
the permeability of constructs, or the capacity of a construct to admit new elements. In
addition, I discussed the cycles of construction: the Circumspection-Preemption-
Control (C-P-C) decision-making cycle, the Creativity Cycle of loosening and
tightening of constructions, and the five-phase Experience Cycle. I also discussed the
diagnostic constructs associated with transition, such as anxiety, and disorders of
transition, such as hostility, constriction, and dependency. Finally, I summarised
responses to the need for change, including a brief outline of the concept of role, or a
person’s ongoing pattern of behaviour “that follows from a person's understanding of
how the others who are associated with him in his task think” (Kelly, 1955/1991a, p
97).

I have investigated menopause using a personal construct perspective, in part,
because this perspective provides a theory of change (Viney, 1995). Viney (1995) has
elaborated the way that: “the concepts of transition and crisis, the link between
transition and emotion, the cycle of loosening and tightening, and the cycle of
validation-invalidation” (p 111) make personal construct psychology so valuable as a
theory of change. A personal construct approach also allows “the articulation of deeply
personal meanings” (Neimeyer, 1993, p230), rather than a reliance on classification or
categorisation. A personal construct approach, therefore, is particularly relevant for
investigating the changes of the menopausal transition.

Using this personal construct perspective, it is clear that women's experience of
menopause varies from individual to individual, and that menopausal experience spans
a continuum. It ranges from the experience of many women who do not construe
menopause as problematic, to that of others who experience severe difficulty. Even when it is construed at the most minimal level, however, menopause of necessity constitutes a change. This is reflected in traditional usage in which menopause is referred to as “The Change” (Formanek, 1990; Gifford, 1994). Similarly, in medical literature the term “the menopausal transition” is often used to describe the process of change taking place (Dennerstein et al., 1997; McKinlay et al., 1992).

Kelly (1955/1991a), in his major work, in a subsection referring to “life's vicissitudes” (p 485), observed that “it is in the transitions from theme to theme that most of life's puzzling problems arise” (p 486). I propose that the experience of menopause may represent just such a transition that may be challenging for women who construe the changes of menopause as significant.

4.2.1 Menopause and Invalidation

Kelly (1955/1991a) argued strongly against the idea that the psychology of personal constructs could be construed as an intellectual model: “the psychology of personal constructs is built upon an intellectual model, to be sure, but its application is not intended to be limited to that which is ordinarily called intellectual or cognitive. It is also taken to apply to that which is commonly called emotional or affective and to that which has to do with action or conation” (p 130). It was Kelly's belief that “a large portion of human behaviour follows nameless channels that have no language symbols, nor any kinds of signposts whatsoever” (p 130). He observed that: “a certain construct may be called a physical construct, not so much because it is subsumed within a ‘physical’ system of constructs, but because it presumes to deal with elements that have already been construed as inherently ‘physical’” (p 152). Women's experiences of menopause are therefore likely to involve physical constructs. In that context, Kelly’s (1955/1991a) description of validation seems particularly relevant. In the following quotation I have replaced the male pronouns of the original, with female pronouns, to
emphasise the relevance of the passage to a specifically female phenomenon: “a person commits herself to anticipating a particular event. If it takes place, her anticipation is validated. If it fails to take place, her anticipation is invalidated” (p 158). Menopause, defined as the cessation of menses (Utian, 1991), is, of its very nature, potentially invalidating, and therefore likely to produce anxiety. Even when menopause is expected, with the exception of surgically or chemically induced menopause, its timing cannot be predicted accurately.

In “A Constructivist Model Of Psychological Reactions To Physical Illness And Injury,” Viney (1990) proposed that: “anticipations through the use of the construct system of already proven effectiveness may not be possible for seriously ill people … such anticipation may also not be possible if illness-associated events are new to these people, so that new constructs are needed” (p 119). Uncertainty may be an appropriate reaction to such physical changes (Viney, 1983). In the context of the changes of menopause, some women also find that they do not know what is happening to them, and find it hard to predict what will happen next, as I report in Chapter 5. Invalidation, at least of physical constructs, could be the very essence of menopause for some people.

Furthermore, there are, as discussed in Chapter 2, a limited number of inadequate models that dominate the descriptions of menopause. To some extent these models represent stereotypes, which may or may not accurately reflect an individual woman’s experience. As a result, as Fransella (1977) says, “If we see stereotyped construing as a set of constructs used in a constellatory or preemptive way and about which there is agreement between members of the given culture, then one would expect a certain amount of invalidation to occur in the normal course of events” (p 61). The dominant models of menopause present women with patterns of behaviours that can seem prescriptive. Individual women may therefore feel invalidated, and anxious,
because their experience does not conform to that which is represented by, for example, the medical model, or the natural life model.

### 4.2.2 Gender and Role

There is an aspect to the validation and invalidation of women’s experience of menopause that relates to gender roles. In discussing the personal construction of one’s role, Kelly (1955/1991a) explains that much of a person’s social life “is controlled by the comparisons he has come to see between himself and others” (p 131). In this regard, as Salmon (1985) commented: “Of all aspects of our lives, perhaps gender is the most fundamental. As such, it may represent what, most fundamentally, most significantly, we embody” (p 181). Bannister (1977) also called male and female roles: “the root personae of society” (p 35). If our construing about our “physical modality” (Salmon, 1985, p 173) is indeed so fundamental, then construing about gender-related physical changes is likely to be linked to a woman’s construing of her role.

Kelly (1955/1991a) argued that “validation can be viewed as affecting the construction system at various levels … with those constructs that are functionally closest to the constructs upon which the original prediction was based being most affected by validational experiences” (p 159). Menopause, in this light, can be seen in two ways. Firstly, it can be seen as one of a series of physical events confirming and validating predictions about a gender role. Secondly, it can be seen as a change that could invalidate a woman's predictions about her role, if the predictions are based on construing about herself in relation to her menstrual cycle, and her ability to bear children.

### 4.2.3 Emotion and the Need for Change

Women whose constructs are invalidated, and who have difficulty in predicting what will happen, are likely to experience a need for change in their construct systems. Personal construct theory in relation to change has been discussed in Chapter 3, and
Kelly’s (1955/1991a; 1955/1991b) theory of the link between the need for change and a range of negative emotions: threat, fear, anxiety, and guilt, has been presented. In accordance with Kelly’s definition, people feel anxious when they recognise that events are outside the range of their construct systems, or “if the implications of change are, for some reason, outside the range of the person's construing” (Dalton, 1993, p 110). In personal construct theory, anxiety is not classified as either good or bad, but as a precondition for making revisions (Kelly, 1955/1991a). Expressions of positive emotion indicate successful construing, feelings of satisfaction, and that change has taken place (McCoy, 1981).

4.2.4 Decision-Making and the Circumspection-Preemption-Control (C-P-C) Cycle

A crucial aspect of the current context for menopausal women, is that they are aware of conflicting information about the nature and management of menopause (Abraham et al., 1995; Hamburger, 1990). As I noted in Chapter 2, material derived both from within the medical model, and from competing models, presents arguments about how women should experience or manage menopause, focused on the potentially threatening topics of breast and uterine cancer, heart disease, osteoporosis, etc. Women are also aware of the significance of the choices to be made during the menopausal transition: that current life expectancy for women is such that much of their lives (up to one-third) will be lived in the light of the decisions that they make at menopause (Utian, 1997).

In this context, women may experience confusion and difficulty in moving through the Circumspection-Preemption-Control (C-P-C) decision-making cycle to a satisfying resolution. A woman may find that she is stuck in the circumspection phase of the cycle, endlessly considering the competing, or conflicting alternatives. Alternatively, she may act impulsively to pre-empt her choice, without feeling satisfied.
with her decision. In either case, she may find it difficult to complete the C-P-C cycle satisfactorily.

4.2.5 Elaboration and the Creativity Cycle

Despite the apparent availability of information on menopause, women report a lack of opportunities for discussion of their experience of menopause, outside medical contexts. In personal construct terms, they may therefore have difficulty in developing elaborated constructs about their menopausal experience. This would inhibit their engagement in the loosening phase of the Creativity Cycle, and therefore their ability to complete the cycle by tightening their constructions, and moving to reconstruction.

Clearly opportunities for reflection and elaboration are important in providing a suitable context for the creative process that leads to reconstruction. While, as Dalton (1993) observes, “the notion that there are always alternative constructions to choose among when dealing with the world suggests the freedom we all have to change” (p 116), much depends on having the opportunity to develop those alternatives. Dalton (1993) gives an example of this process of change: “as a woman I may have been taught that there are only certain roles open to me in life and that there are many things that I am expected to do. As a construing person, however, there may come a point when I reflect on these expectations and decided to experiment with change” (p 100). Freedom comes with “our ability to construe our circumstances and then reconstrue them” (p 99). Those women who have opportunities to reflect, elaborate their construing, and develop alternative constructions, are more likely to be able to make the transition to a reclassified and satisfying role.

Viney (1995) observes that: “transition eventually results in people's acting on their worlds, through elaboration of their own construing, by exploration and extension” (p 112). Women's sense of control is a critical factor in this link between the creativity and decision-making cycles. As Dunnett (1985) said: “control is
important in relation to creativity in that the purpose of the Creativity Cycle is to provide new constructs with which to construe new events, and such construction is ultimately dependent upon an ability to enact experiments” (p 42). That is, “control is the link between thought and action” (Dunnett, 1985 p 46).

In summary, women who construe the changes of menopause as significant, may have problems in relation to the cycles of construction and the processes of transition, and therefore may experience difficulties in reconstruction and the successful negotiation of the menopausal transition.

4.2.6 The Experience of Menopause and the Experience Cycle

A woman’s experience of the menopausal transition can be seen as an example of the Experience Cycle. Interestingly, there are some parallels between the stages of the Experience Cycle: anticipation, investment, encounter, confirmation or disconfirmation, and constructive revision, and the phases of menopause proposed by Ballard et al (2001). Without wanting to claim a definitive status for that model, the similarities in phases are conspicuous. Those researchers describe menopause as status passage of five stages: expectation of symptoms, experience of symptoms and loss of control, confirmation of menopause, regaining control, and freedom from menstruation. In each case Stage 1 involves *anticipation*. Stage 3 of the Experience Cycle, *encounter*, is similar to Stage 2 of the menopause passage, *experience of symptoms and loss of control*. Stage 4 of the Experience Cycle, *confirmation or disconfirmation*, is again remarkably similar to Stage 3 of the menopause passage, *confirmation of menopause*. The final stage of the Experience Cycle, *constructive revision*, also bears a resemblance to the final stages of the menopause passage, *regaining control and freedom from menstruation*. It is only Stage 2 of the Experience Cycle, *investment*, which does not have a parallel in the menopause passage that Ballard et al (2001) described. My argument for this research has been that women’s total experience of the menopausal
transition is an example of the Experience Cycle, and that specific difficulties of
construction involving the C-P-C Cycle, and the Creativity Cycle, may arise for women
anticipating, or experiencing, the menopausal transition.

4.2.7 Dimensions of Transition

Kelly (1955/1991a) discussed two different strategies a person might adopt if
something “has gone wrong with his anticipation system … (and) there are too many
rude surprises. It becomes apparent that he must do something about his role. The
most obvious thing to do is to start reclassifying his role within the context of some of
his personal role constructs” (p 134). As a person reconstrues, however, “he may either
rattle around in his old slots or he may construct new pathways across areas which were
not previously accessible” (p 128).

Kelly (1955/1991a) saw both aggression and hostility as dimensions of
transition. While aggressiveness is the active elaboration of one’s perceptual field and
an aggressive person seeks to explore uncharted areas, hostility is the continued effort
to extort validational evidence in favour of the type of social prediction that has already
proved itself a failure. A person might adopt a hostile strategy such as, in Kelly’s
(1977) words: “tinker with the validational evidence” (p 28) to avoid reconstruction.
Or, in Fransella’s (1977) example, “we can just not ‘see’ examples of invalidation” (p
61). Similarly Bannister (1977) proposed that we handle our anxieties in at least two
ways, by becoming aggressive and actively exploring the area (dilation) or withdrawing
from the area altogether (constriction).

4.2.8 Construing Menopause

A woman's experience of the menopausal transition can be seen as an example
of the Experience Cycle. She anticipates what will happen, makes an investment in the
prediction, encounters menopausal events (however slight), is confirmed or
disconfirmed in her predictions, and either revises her constructions, or maintains them.
During the transition, women may construe the changes of the menopausal transition at a superordinate, or subordinate, level. They may engage with the changes using aggressive strategies, embarking on reconstrual through the construction of new pathways. Alternatively, they may attempt to limit change by using hostile strategies, by ‘slot-rattling’ in their construction of themselves, or by constricting their construing. They may find it difficult to engage in, or complete the C-P-C Cycle, or Creativity Cycle, or they may find their predictions are not validated. They may experience anxiety, or “the recognition that the events with which one is confronted lie outside the range of convenience of one's construct system” (Kelly, 1955/1991a, p 495), as anxiety is one of the emotions, or diagnostic constructs, associated with transition. Alternatively, women may successfully complete the cycles of construction to arrive at validated predictions and a feeling of control.

4.3 A Personal Construct Model of Menopause

Kelly’s (1955/1991a) theory of transition provides an enlightening perspective from which to consider the changes of menopause. Using this perspective as a framework, I developed a personal construct model of menopause. I presented an earlier version of the model to the European Personal Construct Association Conference in 2000. This was later published (Foster & Viney, 2001).

The personal construct model of menopause encompasses two over-arching meanings of menopause. The first reflects the experience of those women who construe menopause as meaning change that lies within the range of convenience of their construct system and that is consistent with their predictions about themselves. The second reflects the experience of those women who construe menopause as meaning significant physical and/or psychological change that lies outside the range of convenience of their construct system and invalidates the predictions of women trying to anticipate events by construing their replications. As women enter an Experience
Cycle relating to menopause, their experience of, and construing of, menopause will lead to adjustments of their construct systems. Within the model these adjustments are represented as five construing patterns.

**Meaning 1: Basic proposition**

Menopause means change that lies within the range of convenience of women’s construct systems and is consistent with their predictions about themselves.

There are two construing patterns associated with Meaning 1: *Limited change*, and *Hostility*.

**Structural Pattern A: Limited Change**

Subsidiary Propositions

A(i) menopausal changes may validate women's predictions about their core role if they construe their role in relation to gender related physical constructs

A(ii) women's predictions about themselves will not be invalidated by menopausal changes when change is construed as minor and limited to subordinate constructs

A(iii) when women construe change as minor and limited to subordinate constructs, or their predictions are validated, they will not experience anxiety and feel the need for change.

**Structural Pattern B: Hostility**

Subsidiary Propositions

B(i) if women have impermeable constructs about themselves, they may engage in construing strategies that reflect hostility, in order to construe menopause as a minor physical change

B(ii) if women engage in hostile strategies in their construing of menopause, they will not construe themselves as needing to change.

**Meaning 2: Basic proposition**
Menopause means significant physical and/or psychological change that lies outside the range of convenience of women’s construct systems, and invalidates the predictions of women trying to anticipate events by construing their replications.

There are three construing patterns associated with Meaning 2: *Limitation and Invalidation, Reconstruction and Validation, and Intervention.*

**Structural Pattern C: Limitation and Invalidation**

**Subsidiary Propositions**

C(i) when women's existing construct systems are not adequate for successful predictions about menopause, and they become aware of the need for change, they may experience the emotions of transition: anxiety, threat, fear or guilt.

C(ii) women will have difficulty elaborating their construing about menopause, and engaging in the creativity cycle, when opportunities for discussion about menopause are limited.

C(iii) women will have difficulty in moving through the C-P-C Cycle to a satisfying choice when they are not able to elaborate their construing and information is conflicting or limited.

C(iv) when women have difficulty in engaging in, or completing, the cycles of construction they will not be able to move to creative reconstruction and will continue to experience the emotions of transition.

**Structural Pattern D: Reconstruction and Validation**

**Subsidiary Propositions**

D(i) when women's existing construct systems are not adequate for successful predictions about menopause, and they become aware of the need for change, they may experience the emotions of transition: anxiety, threat, fear or guilt.
D(ii) when women have opportunities to elaborate their construing about menopause, their engagement in the creativity cycle and exploration of their constructions of the change will be facilitated

D(iii) if women are able to elaborate their construing about menopause in a context where they feel well-informed, they are likely to move through the C-P-C Decision-making Cycle to make satisfying choices in reconstruing themselves

D(iv) when women have opportunities to make satisfying choices in reconstruing themselves in relation to menopause, their predictions are more likely to be validated, they are likely to experience a reduction in the emotions of transition such as anxiety, and an increase in feelings of control, hope and positive feelings.

**Structural Pattern E: Intervention**

This pattern closely follows the pathway shown in Structural Pattern D: Reconstruction And Validation. Pattern D is used to capture the notion that a woman may be perfectly capable of achieving reconstruction and validation on her own. Pattern E represents the same process when it occurs through an intervention. It therefore starts from the same point as proposition D(ii). The difference in the two patterns is that the concept: “elaborate their construing about menopause”, which occurs in Pattern D(ii), is elaborated to specify the process: “explore their individual meanings of menopause by sharing their experience” in Pattern E(i).

Subsidiary Propositions.

E(i) if women are able to explore their individual meanings of menopause by sharing their experience, their engagement in the creativity cycle and elaboration of their constructions of the change will be facilitated

E(ii) if women are able to elaborate their construing about menopause in a context where they feel well-informed, they are likely to move through the C-P-C Decision-making Cycle to make satisfying choices in reconstruing themselves
Figure 1. A Personal Construct model of menopause

Change within range of convenience consistent with predictions about self

Limited change

Sub-ordinate construing

Gender related construing

Validation of core role construing

Hostile strategies

No emotions of transition

No need for change

MENOPAUSE MEANS

Significant physical and/or psychological change outside range of convenience/invalidates predictions

Need for change, emotions of transition

Limited opportunities to explore

Cannot engage in creativity cycle

Conflicting information

Cannot complete CPC cycle

Limited construing

Invalidation

Emotions of transition

Explore individual meanings/share experience

Opportunity to explore

Feels well-informed

Engages in Creativity cycle

Control/choice

Engages in CPC cycle

Elaborated construing

Reconstruct self

Validation

Reduced emotions of transition, increased positive emotions

Limited construing

Gender related construing

Impermeable construing

Sub-ordinate construing

Limited change

Hostility

(Limitation)

(Hostility)
E(iii) when women have opportunities to make satisfying choices in reconstruing themselves in relation to menopause, their predictions are more likely to be validated, they are likely to experience a reduction in the emotions of transition such as anxiety, and an increase in feelings of control, hope and positive feelings.

4.4 Themes Related to Patterns of Construing in Model

The patterns of construing represented in the personal construct psychology model of menopause, can be identified by themes occurring in women’s meanings of menopause. In this section I describe the themes characteristic of the construing patterns of the model. An outline of the model and the themes relating to the construing patterns can be found in Appendix A. In Chapter 5, I shall elaborate these themes in women’s construing in more detail, and give descriptions and examples of the themes.

The first pattern of construing in the model is “Limited Change,” in which change is construed as minor, or as a validation of gender related predictions. The theme that characterises this pattern of construing is “menopause means no change.”

The second pattern is “Hostility.” This pattern is characterised by impermeable constructs, and the use of strategies to construe menopause as a minor physical change, despite a description of symptoms. The theme associated with this pattern is “no change stated, but a change described”, that is, a woman might say “menopause meant no change to me”, but then, for example, refer to changes in her sleeping pattern.

The third pattern is “Limitation and Invalidation,” which reflects an inability to satisfactorily elaborate construing and move to control, choice, or creative reconstruction. It is associated with themes of “awareness of change,” “confusion and inability to predict,” “limited opportunities for discussion,” “conflicting or limited information,” “inability to control changes” and “expressions of distressing emotion.”
The fourth pattern is “Reconstruction and Validation,” which represents elaboration, exploration, engagement in the creativity, and decision-making cycles, and a construction of change resulting in satisfying choices, reconstruction, validation of predictions, and reduction in the emotions of transition. The themes associated with this pattern are “elaboration and exploration,” including “discussion” and “information gathering”; “construction of change,” including “making satisfying choices”; “reconstruction and acceptance of change,” including “moving to control,” and “validation of predictions.”

The fifth pattern is “Intervention,” which represents the way that an intervention may be needed to achieve a similar outcome to Structural Pattern 4: “Reconstruction and Validation,” the themes for which are described above.

In Chapter 5 I present Study 1, an account of a study of women’s meanings of menopause. I describe the way I used the personal construct psychology model of menopause and the associated themes, presented in this chapter, as a framework for analysing women’s meanings of menopause in a qualitative study involving 74 women in mid- and later life.
CHAPTER 5

STUDY 1 OF THE MEANINGS OF MENOPAUSE:

ASSESSING CHANGING LIVES
In this Chapter, I report on Study 1: Changing Lives, an exploration of the meanings of menopause for women occupied outside the home by employment (paid or unpaid), or study. Firstly, I describe the research framework, aims of the study, and research questions. Secondly, I report on sampling, and procedure. Thirdly, I present the findings, women’s meanings of menopause, in terms of themes derived from the model described in Chapter 4, and identified in women’s responses to interview questions. Next I outline themes in relation to individual interview questions, and report the results of statistical analysis of the relationships between responses to the interview questions. I then discuss the themes and meanings in relation to the research questions. Following this, I report on an analysis of the data by menopausal status, to provide a picture of the meanings of women at different phases of the menopausal transition, that is, women’s anticipations of menopause, women’s experience of menopause, and women’s recollections of menopause. I then report on the findings of a post interview follow-up process. Finally, I discuss the findings, and limitations of the study.

5.1 A Research Framework

This research was performed according to the ethical codes of the Australian Psychological Society, the University of Wollongong Human Research Ethics Committee, and the National Statement on Ethical Conduct in Research Involving Humans (National Health and Medical Research Council, 2001). In addition, however, the entire research project that I have reported here was undertaken within a specific ethical framework, based on a personal construct perspective. I developed a set of strategies, or as Kelly (1964/1969) says “practical steps,” as a guide for cooperative research with these women.
Strategy 1: That the research process be carried out in a way that respected the other demands of women’s lives: That interviewing be undertaken at convenient times and places, for example, within the confines of the working day.

This strategy is based on the recognition that women tend to have to balance work and family responsibilities and often carry what has been referred to as a double load (Fransella & Frost, 1977; Shirazi & French, 1985), so that activities scheduled after working hours might clash with family responsibilities.

Strategy 2: That these co-researchers be invited to contribute to the interpretation drawn from the results of the research.

Research based on personal construct principles should be a cooperative venture between a participant and a “fellow experimenter” (Kelly, 1963/1969), with the researcher working in a reflexive (Bannister & Fransella, 1986; Viney, 1996; Winter, 1992) relationship with the co-researcher. The strength of this approach is that the co-researcher reflects on her own construing, and the perspective of a range of participating women enriches the research. As Viney (1987) has suggested, it may be that the motive for those taking part in psychological research is “curiosity about what will happen and about how they will deal with it when it does” (p 69), and therefore the cooperative enterprise is informative for researcher and co-researchers. This approach allows a freedom for all the people involved, the freedom to communicate with each other, and the freedom to change.

Strategy 3: That co-researchers be invited to guide decision-making on group formation and membership, and location of interviews.

This strategy was adopted to promote a research context for relationships of trust within a brief time. I predicted that women would be more likely to feel comfortable discussing potentially sensitive issues in groups that they had formed themselves (Holmes, 2002). Discussions about menopause may encompass many
issues that women may be reluctant to acknowledge or explore in an unfamiliar, or
nonmedical, context. The Australasian Menopause Society Congress program for 2002
(Australasian Menopause Society, 2002) provides an indication of the issues that
women may have to consider in relation to menopause. The conference covered
disease related topics such as cardio-vascular disease, breast cancer, osteoporosis, and
irregular bleeding; cognitive and mental health issues such as HRT and the brain, and
depression; health issues such as body composition changes, and sexual function; and
social issues such as the experience of menopause for lesbians.

5.2 Aims

In Chapter 2 I investigated conceptualisations of menopause, and concluded that
there is an imbalance in the menopause literature towards a biologically focussed view,
and a lack of attention to the feelings and behaviours of women experiencing
menopause. From a personal construct perspective, it is essential that women’s
individual meanings form the basis of any discussion about menopause. The general
aim of this study was, therefore, to contribute to a more comprehensive knowledge of
women’s meanings of menopause.

Aim 1 was the overarching aim of this study:

1. Using a personal construct approach, to identify and explore the meanings
   that women in mid and later life, occupied outside the home by
   employment (paid or unpaid), or study, use in construing the experience of
   menopause.

A further four aims relate to the same group of women. I present the research
questions, underlying these aims, in the following section.

2. To explore women’s constructions of other people’s construing about
   menopause.
3. To examine whether women maintain, or change, their self-constructions during and after menopause.

4. To determine whether women’s constructions about menopause differ from their constructions about aging.

5. To explore the choices that women, particularly women in manager level positions, make about menopausal change.

5.3 Research Questions

I developed the research questions to test some of the issues discussed in Chapters 2 and 3. Specifically, they refer to social influences on the construction of menopause, the potential for changes in construing the self during menopause, the relationship between women’s constructions of menopause and ageing, and the effect of menopause on women’s employment choices.

1. How do women occupied outside the home construe menopause?

2. How do women construe other people’s constructions of menopause?

3. Do women maintain, or reconstrue, their self-constructions, during and after the process of menopause?

4. Do women’s constructions about menopause differ from their constructions about aging?

5. What choices do women, particularly those in manager level positions, make to deal with menopausal change?

5.4 Sampling

Sampling was purposive, directed at women in mid and later life, occupied outside the home, predominantly in paid employment, and therefore experiencing menopause while in a workplace, or other non-domestic context. The sampling method drew on criterion sampling (Patton, 1990) and judgement sampling (Balnaves & Caputi, 2001) techniques in contacting employed women, and those occupied outside
the home. Sampling was conducted through Women’s Health Centres, the Older Women’s Network, and a large government department, resulting in a sample of women who were in paid employment, volunteer work, full-time study, or were recently retired from full-time work. The employment sectors of education, and health and community services, are two of the three largest area of women’s employment in Australia, and many of the women were engaged in these areas.

In accordance with the Research Questions focussing on women occupied outside the home, women were invited to volunteer predominantly through staff networks. In accordance with Research Strategy 3, presented in Section 5.1, the sample was not randomly selected, nor were women assigned to groups by random selection.

A total of 74 women volunteered for Study 1. Although the use of volunteers affects the generalisation of findings, no other method of recruitment was considered ethically acceptable by the researcher. The guidelines of the University of Wollongong Human Research Ethics Committee, in accordance with the National Statement on Ethical Conduct in Research Involving Humans (National Health and Medical Research Council, 2001) emphasise the importance of voluntary participation in research.

5.4.1 Study 2: Characteristics of the Sample

The characteristics of the 74 women who took part in Study 1 are described in two parts: socio-demographic characteristics and menopausal characteristics. A summary of these characteristics is presented in Tables 1 and 2, at the end of the respective sections.

5.4.1.1 Socio-Demographic Characteristics and Representativeness

Women’s ages ranged from 32 to 79, with a mean age of 50 years, and a median age of 48 years, close to the internationally accepted median age for menopause of 51 (Utian, 1991).
In relation to language and cultural background, 81.1% of the samples were of English speaking background, 13.5% were from a non-English speaking background, and 5.4% were Aboriginal women. This approached the proportions found in the Australian population, with the exception of a slightly higher representation of Aboriginal women. In Australia 16% of the population speaks a language other than English at home, 84% speak only English at home, and Aboriginal people make up 2% of the population (Australian Bureau of Statistics, 2000).

The employment status of women in the sample reflected the sampling strategy targeted towards women in employment. 86.4% of the sample were in paid employment, 5.4% were not in paid work but were volunteer workers, 1.4% were studying, and 6.8% were recently retired. To put this into the perspective of employment rates at the time of this research, the Australian labour force participation rate for women was 54.1% and the unemployment rate for women was 5.5% (Australian Bureau of Statistics, 2001).

The Australian Standard Classification of Occupation (ASCO) (Australian Bureau of Statistics, 1998) was used to classify women’s occupations. A summary of the classifications is presented in Appendix B. Women were employed in occupations ranging from the Intermediate Clerical, Sales and Service Worker level to Manager level. The two major occupational classification levels represented in the sample were 66.2% employed at the Professional level and 8.1% at the Intermediate Clerical, Sales and Service Worker level. In the general population these classifications also represent the occupations with the highest level of women’s participation, however the proportions are quite different: in 1999-2000 20.3% of women were employed at Professional level and 28.2% of women were employed at the Intermediate Clerical, Sales and Service Worker level (Australian Bureau of Statistics, 2000).
The sample differed markedly from the Australian population as a whole in terms of education level, reflecting the employment status of the women. A high proportion of women, 85.1%, held a degree, and 10.8% held a vocational qualification. Of the other women, 2.7% finished school, and 1.4% had not finished school. In the Australian population 10.1% of women hold a Bachelor degree or higher, 6.9% hold an Associate or undergraduate Diploma, 2.8% hold Skilled Vocational and 3.7% hold Basic Vocational qualifications (Australian Bureau of Statistics, 1996).

Table 1

*Summary of Participants’ Characteristics: Age, Employment Status, Levels of Employment and Education, and Cultural Background (%)*

<table>
<thead>
<tr>
<th>Age</th>
<th>Employment status</th>
<th>Level of employment</th>
<th>Level of education</th>
<th>Cultural background</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median 48.0</td>
<td>Employed</td>
<td>Manager</td>
<td>Some</td>
<td>ESB</td>
</tr>
<tr>
<td>Mean 50.0</td>
<td>86.4</td>
<td>5.4</td>
<td>School</td>
<td>81.1</td>
</tr>
<tr>
<td></td>
<td>Volunteer</td>
<td>Profess’l</td>
<td>1.4</td>
<td>NESB</td>
</tr>
<tr>
<td></td>
<td>5.4</td>
<td>66.2</td>
<td>Fin. school</td>
<td>13.5</td>
</tr>
<tr>
<td></td>
<td>Study</td>
<td>AssProf’l</td>
<td>2.7</td>
<td>Aborig’l</td>
</tr>
<tr>
<td></td>
<td>1.4</td>
<td>5.4</td>
<td>Vocational college</td>
<td>5.4</td>
</tr>
<tr>
<td></td>
<td>Retired</td>
<td>Advanced Clerical</td>
<td>10.8</td>
<td></td>
</tr>
<tr>
<td></td>
<td>6.8</td>
<td>Intermed. Clerical</td>
<td>University</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>6.8</td>
<td>85.1</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Study</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
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<td>1.4</td>
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<td></td>
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<td>Retired</td>
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<tr>
<td></td>
<td></td>
<td>6.8</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
5.4.1.2 Menopausal Characteristics

Definitions of menopausal status are not precise, particularly in the general community, as I noted in Chapter 2. They are also complicated by the use of hormone replacement therapy. Despite this difficulty, I theorised that particular patterns of construing might occur in relation to different menopausal stages. Women were therefore asked to nominate what stage they thought they were experiencing. Of the women in Study 1, 40.5% of women defined themselves as premenopausal, 27.1% as perimenopausal or menopausal, and 32.4% as postmenopausal. The confusion about these stages must be stressed. In the course of the interviews it became clear that some women who nominated themselves as premenopausal, were in fact reporting symptoms. It appeared that they thought they were premenopausal until the final cessation of menses, when they would become postmenopausal, leaving no possibility for being defined as menopausal. On the other hand, some women taking HRT defined themselves as postmenopausal because they no longer had symptoms. I will discuss the lack of clear definitions in Section 5.8.1 dealing with limitations of the research.

The onset of menopause is also an imprecise notion. Women reported onset at a range of ages, from 35 to 56 years. There was one exception to this, in the case of a woman who experienced medically induced menopause at 26. The median age was 48. In relation to the use of medication, 31.1% of women reported using hormone replacement therapy at some time, 10.8% reported using natural therapies at some time, and 58.1% of women reported that they had used no medication.
Table 2

Summary of Participants’ Characteristics: Menopausal Status, Age of Onset, and Medication (%)

<table>
<thead>
<tr>
<th>Menopausal status</th>
<th>Age of onset</th>
<th>Medication</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre 40.5</td>
<td>Median 48.0</td>
<td>HRT 31.1</td>
</tr>
<tr>
<td>Peri 9.5</td>
<td>Mean 47.1</td>
<td>Nat. 10.8</td>
</tr>
<tr>
<td>Meno 17.6</td>
<td>27.1</td>
<td>None 58.1</td>
</tr>
<tr>
<td>Post 32.4</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*a* Not a precise measure: Women’s estimate.

5.5 Procedure

It was planned that women would be given an opportunity to explore their construing through the processes of responding to open-ended questions, in an individual or group interview.

5.5.1 Mode of Interview

Women were interviewed in two modes: in groups or individually. Women nominated which mode they preferred. Women contacted through Women’s Health Centres and the Older Women’s Network were interviewed in groups. Women contacted through staff networks in the government department were interviewed either in groups or individually.

Group formation was guided by the women, who nominated group membership, usually based on existing work groups. The strategy of working with existing work groups, in which group formation had already taken place, was used to facilitate the group process, and provide a context for developing relationships of trust within a brief time. I anticipated that women would be more likely to feel comfortable discussing potentially sensitive and important issues with those who were familiar to them. In
accordance with Research Strategies 1 and 3, interviewing was carried out at locations chosen by participating women.

5.5.2 Information and Consent

Before the interviewing commenced, all the women were asked to read the Information Sheets (Appendix C) giving an outline of the project and advice that women might withdraw from the research at any time without negative consequences. Women were asked to sign a Consent Form (see Appendix D) indicating their willingness to participate in the project. I advised the women of the degree of confidentiality they could expect, and gave them contact details of the relevant person if they had concerns or questions.

I asked the women to complete a short questionnaire requesting their age, age at onset of menopause if applicable, current or past treatment for menopause, type of employment if applicable (Appendix E).

5.5.3 Confidentiality

The women participating in this study were given an assurance that their identity would be confidential. Women in groups were advised of the need to respect confidentiality when working in a group, and were advised that confidentiality is dependent on the commitment of each participant. I gave an undertaking not to disclose information given in the course of the research in any way that could identify a participant. A participant number was used for identification purposes in recording and transcribing data. After transcription, I assigned a set of pseudonyms to the participant numbers, avoiding names actually belonging to any of the women. In presenting direct quotations from women’s speech, I have used these pseudonyms to protect the confidentiality of participants.
5.5.4 Data Collection

5.5.4.1 Interview Schedule

Women were asked to identify themselves as pre-menopausal, menopausal or post-menopausal. Interviews with premenopausal women consisted of four questions, and menopausal and post-menopausal women were asked four additional questions. The interview schedule follows, and also appears in Appendix F.

(i) What does menopause mean for you, the good things and the bad?
(ii) What do you think menopause means for other people?
(iii) Does menopause mean changes in your life? What sort of changes?
(iv) How do you feel about getting older?

Additional questions for menopausal and post-menopausal women:
(v) What is good about menopause?
(vi) What is bad about menopause?
(vii) Has menopause changed the way you think about yourself?
(viii) Are there any factors that you think affect/affected your experience of menopause?

Finally women were asked if they had anything they would like to add, or advice they would like to give to other women.

The questions were designed to elicit responses that would relate to the Research Questions, presented in Section 5.3. Question 1 was designed to encourage women to explore their meanings of menopause, and relates to Research Question 1, “How do women occupied outside the home construe menopause?” and to Research Question 5, “What choices do women, particularly those in manager level positions, make to deal with menopausal change?”
Question 2 was designed to elicit additional meanings of menopause, as well as women’s constructions about the social context in which menopause is experienced. It relates to Research Question 2, “How do women construe other people’s constructions of menopause?” and also to Research Question 5, quoted above.

Questions 3, and 7, asked about change in a way that allowed a description of maintenance of construing, or a process of reconstruing the self. Questions 3, and 7, relate to Research Question 3, “Do women reconstrue, or maintain their self-constructions, during and after the process of menopause?”

Question 4 asked specifically about the meaning of aging, in order to determine whether women’s meanings of menopause were distinct from their meanings of aging, as aging is often associated with menopause (Friedan, 1994; Sheehy, 1995). Question 4 therefore relates to Research Question 4, “Do women’s constructions about menopause differ from their constructions about aging?”

Questions 5 and 6 respectively, asked “What is good about menopause?” and “What is bad about menopause?” in order to specifically identify any meanings, for menopausal and post-menopausal women, that were not covered in Question 1. They relate to Research Question 1.

Question 8 was designed to allow the identification of any cultural, social, or employment factors that might have been important to women’s experience. This question, together with Questions 1 and 2, relate to Research Question 5, “What choices do women, particularly those in manager level positions, make to deal with menopausal change?” Finally, women were asked if there was anything they would like to add, or if they had any advice for other women.
With the permission of the women, I used audiotape to record the interviews for later analysis. This technique obviated the need for extensive note taking and allowed me to concentrate on eliciting women’s responses. The interviews concluded with debriefing. The interview duration was between 20 minutes and one hour depending on menopausal stage, that is, whether four or eight questions were used, and whether interviews were with an individual or a group.

5.5.4.2 Post Interview Follow-up

Following the interviews, after the data had been analysed for themes and meanings, a report of the findings was sent to all participating women, with a request for comment.

5.5.5 Post-Interview Treatment of Data

Transcripts were made of the audio tapes from all interviews. The methodology for the analysis included two approaches. Working directly from the raw information, and drawing from the entire data set, a list of themes with definitions of each, was compiled (Appendix G). This initial approach was data-based, in which data were closely examined, and coded by naming and categorising. Because of the closeness of the code to the data, this method was likely to obtain validity against criteria and construct variables (Boyatzis, 1998). A high interrater reliability ratio was also likely (Boyatzis, 1998), and occurred in this study, as I shall describe below.

The data-based analysis was combined with a theory-based approach in which the themes identified from examination of the data were further classified according to the patterns of construing of the personal construct model of menopause, described in Chapter 4. This two-step process was used as a correction for the possibility of the “projection on the part of the researcher” (Boyatzis, 1998, p 35) that can occur in a purely theory-based analysis, and also as validity check for the model.
The interview was the unit for analysis for each woman. After the development of the code of themes and definitions, all interview transcripts were reexamined using the code. The themes occurring in individual transcripts were coded using NVivo software, using identification numbers for each woman. The aim of this research was to identify the themes that were common to a number of women, rather than to compare individual women on frequency of occurrence of themes. Each interview was therefore coded simply for the occurrence of a theme, regardless of the number of times a woman might mention it.

A random sample of 30% of participants was generated using SPSS. The sample was given to an independent rater, who examined the transcripts, and recorded the occurrence of themes for each woman. The relationship between the coding frequencies for the themes recorded by the independent rater, and the researcher, was investigated using Spearman’s Rank Order Correlation. The result showed a strong positive correlation $r(49) = .82, p < .01$.

A data set was compiled showing the number of women whose meanings reflected each theme. The full set of themes and frequencies is included at Appendix H.

5.5.6 Presentation of Direct Quotations

In Study 1, transcripts were made from speech. I have therefore edited direct quotations in the following very minor fashion: punctuation has been added for clarity, vocalisations such as “um,” “er,” “you know,” and “sort of” have been removed, and if words are repeated, such as “and and,” the second word has been deleted. Where words are repeated for emphasis they have been retained and noted in the text. Any additions to the text that have been made for clarity, or comments, for example, “sic” are shown in square brackets, in the following way [sic].
5.6 The Meanings of Menopause

The meanings of menopause for the women in this Study were grouped by theme, as reported in Section 5.5.5. In this Section, I discuss the themes in order of frequency of occurrence, based on the percentage of women whose meanings reflected a particular theme.

I then report on the themes from three additional perspectives, firstly according to Interview Question, in Section 5.6.1.4. Secondly, in Section 5.6.1.5, I summarise the results in relation to the Research Questions that I reported in Section 5.3. In addition, the relationship between the themes, and the Research Questions, is noted in the discussion of themes where appropriate. Finally, in Section 5.6.2 I report on the themes in relation to menopausal status.
Table 3

Frequency of Major Themes in Interview Question Responses

<table>
<thead>
<tr>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>Q5</th>
<th>Q6</th>
<th>Q7</th>
<th>Q8</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sympt&lt;sup&gt;a&lt;/sup&gt;</td>
<td>Sympt&lt;sup&gt;a&lt;/sup&gt;</td>
<td>Body</td>
<td>Body</td>
<td>Relief</td>
<td>Sympt&lt;sup&gt;a&lt;/sup&gt;</td>
<td>Emot&lt;sup&gt;b&lt;/sup&gt;</td>
<td>Emot&lt;sup&gt;b&lt;/sup&gt;</td>
</tr>
<tr>
<td>54%</td>
<td>43%</td>
<td>30%</td>
<td>48%</td>
<td>30%</td>
<td>23%</td>
<td>23%</td>
<td>30%</td>
</tr>
<tr>
<td>Period</td>
<td>Mother&lt;sup&gt;c&lt;/sup&gt;</td>
<td>Sympt&lt;sup&gt;a&lt;/sup&gt;</td>
<td>Emot&lt;sup&gt;b&lt;/sup&gt;</td>
<td>Health</td>
<td>Body</td>
<td>Body</td>
<td>HRT&lt;sup&gt;d&lt;/sup&gt;</td>
</tr>
<tr>
<td>47%</td>
<td>28%</td>
<td>24%</td>
<td>42%</td>
<td>14%</td>
<td>18%</td>
<td>18%</td>
<td>27%</td>
</tr>
<tr>
<td>Unable</td>
<td>Stigma</td>
<td>Emot&lt;sup&gt;b&lt;/sup&gt;</td>
<td>Accept</td>
<td>Marker</td>
<td>Emot&lt;sup&gt;b&lt;/sup&gt;</td>
<td>Aging</td>
<td>Mother&lt;sup&gt;e&lt;/sup&gt;</td>
</tr>
<tr>
<td>to pred&lt;sup&gt;e&lt;/sup&gt;</td>
<td>26%</td>
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<td>46%</td>
<td></td>
<td></td>
<td></td>
<td>Money</td>
<td>11%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emot&lt;sup&gt;b&lt;/sup&gt;</td>
<td>Unable to pred&lt;sup&gt;e&lt;/sup&gt;</td>
<td>No</td>
<td>Futr&lt;sup&gt;f&lt;/sup&gt;</td>
<td>HRT&lt;sup&gt;d&lt;/sup&gt;</td>
<td>Loss</td>
<td>Strats&lt;sup&gt;g&lt;/sup&gt;</td>
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<td>pred&lt;sup&gt;e&lt;/sup&gt;</td>
<td>change</td>
<td>19%</td>
<td>14%</td>
<td>14%</td>
<td>Doctor</td>
<td></td>
</tr>
<tr>
<td></td>
<td>24%</td>
<td>19%</td>
<td></td>
<td></td>
<td></td>
<td>Family</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>16%</td>
<td></td>
</tr>
</tbody>
</table>
5.6.1 Themes in Women’s Responses

Research Question 1 was concerned with the way in which women occupied outside the home construe menopause. At the broadest level, the set of themes that I will report, is a summation of women’s meanings revealed in this Study. The meanings reflect constructs that range from those about the self and the body, to those about the social, cultural and employment context. Inevitably some women spoke more eloquently or cogently than others, and it is possible that their voices are represented slightly more often than those of other women. I have, however, made an effort to ensure that the voices of all the women are represented in this document.

5.6.1.1 Major Themes 1: Occurred in 70% or More of Responses

The first group of four themes is composed of those that occurred in 70% or more of women’s responses. They appear below in Table 4. These themes predominantly reflect negative emotions, and an awareness of change. In terms of the personal construct model of menopause, the themes are characteristic of Structural Pattern C: Limitation and Invalidation, described in Chapter 4.

Table 4
Themes Occurring in 70% of Responses or More

<table>
<thead>
<tr>
<th>Theme</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Awareness of changes: Symptoms, e.g. hot flushes</td>
<td>88</td>
</tr>
<tr>
<td>Expressions of distressing emotion</td>
<td>74</td>
</tr>
<tr>
<td>Unable to predict what will happen</td>
<td>70</td>
</tr>
<tr>
<td>Awareness of changes to the body</td>
<td>70</td>
</tr>
</tbody>
</table>
It was clear that menopause meant change of some kind, for most of the women interviewed. For 88% of the women interviewed, the most frequently occurring theme was *physical or psychological symptoms* of menopause. In addition, 74% of the women *expressed distressing emotion*, such as anxiety. Seventy per cent of women reported feelings of confusion, and *an inability to predict what would happen*, or was happening, or, in the case of postmenopausal women, in remembering their experience of menopause. An *awareness of changes to the body* and feelings of loss of control were reported by 70% of women.

*(a) References to Symptoms (88%)*

This theme is included in a grouping of themes dealing with *Awareness of Change* (Appendix G). A major meaning of menopause for these women was the possibility, or actuality, of physical or psychological symptoms, which ranged from mild to extremely severe. This emphasis on symptoms strongly suggests that women understood menopause to mean *change*, ranging from physical changes to much more comprehensive change, and indeed, at its most basic biological level, menopause is by definition a change. An awareness of change carries with it an awareness of the need for new thinking, or, in personal construct terms, the need for changes to a construct system. It appears that this sample of women was strongly aware of the need for change that menopause would bring, or had brought, to them.

One of the notable findings of this research, which relates particularly to Research Question 5, was that women were making choices of *attempting to continue with their normal lives whilst experiencing changes* resulting from a range of symptoms. Women gave poignant accounts of trying to appear controlled and professional at work, while suffering from excessive bleeding, or extensively disrupted sleep. There are some comparisons that can be made between symptoms of this magnitude, and the experiences of some new mothers who cope with distressed babies,
and similarly suffer extensively disrupted sleep. A crucial difference, however, is that
while most businesses may not yet be “family friendly,” childbirth and parenting most
often takes place in a context of joyousness and societal approval. Menopause,
however, is still shrouded by taboos. It is clear from women’s accounts that aging is
feared, and menopause is seen as the gateway to aging. An admission of menopausal
status is seen as an admission of *aging*, with aging workers still not welcomed in the
workplace, despite the demographic changes that must eventually lead to a change in
these attitudes, and legislation aimed at preventing age based discrimination (Law

I give some examples of the way women described their symptoms.

Dawn said: “When I first started with menopause … the first thing was the
irrational periods, that were just all over the place, but I also had lots of hot flushes,
feeling sick, feeling very uncomfortable, bursting into tears.” Stella also found the
symptoms difficult: “I couldn’t stand the hot flushes. I’ve never liked being hot. I get
quite claustrophobic if I’m hot and want to run away … I’d go bright red and I’d start
to get irritable.” Nora was distressed by hot flushes: “I started to get very extreme hot
flushes, where I thought that I was perspiring, and I was, I was feeling very clammy.
You could feel it welling up from within. And it … seemed to me it lasted a long time,
but in actual fact it was only minutes.” Yolande described her symptoms as: “the mood
changes … I didn’t like that at all, and tiredness at times … I just had to lie down all the
time, always feeling so tired.”

Alison was dealing with different symptoms: “Very depressed, very moody, all
sorts of bloating, and constipation. Just a general feeling of ill health.” For Enid,
menopause meant yet another range of symptoms:

Premenstrual tension, getting bigger, and over a longer period of time. And that
meant quite dramatic mood swings, and quite high stress levels. And … that
has been really unpleasant … It means being awake at night, it means being agitated, it means … needing to use the loo a lot.

Some women, such as Cecily, found that they had not predicted their symptoms, and that invalidated her construing of herself:

I’d always been a little bit cynical about premenstrual tension because I’d never had it, and then wow, boomo, I’m getting premenstrual tense like you wouldn’t believe … bad temper went with it, extra bad temper, not normal bad temper, went with this premenstrual tension, and depression, which was something that I’d never ever experienced.

Prue was one of the women who found it difficult to find a solution:

The first stage that signaled that menopause was coming was just suddenly … a period that I had didn’t stop, and it just went on and on and on for 77 days … After about 30 days I went to a GP who said “oh it must be menopause, I’ll put you on HRT,” and then put me on this program … instead of it regulating it, it made it worse. And I went back to her … I was put on this treatment and it made it worse … So I went off to another medico. The other medico said “look if your own doctor has prescribed this, I would say that that would be the right thing for you.” So I just continued taking it, and then it went on for 77 days, and it got very very very very heavy [emphasis in original]. I was trying to work during this time, and then finally it did get so bad that I took myself off to casualty.

Only one woman in the study reported having to take time off work because of her symptoms. Winnie found that menopause changed her life:

I started to feel dizziness, headaches, terrible mood swings, incredible anger, started to think about death all the time … all those symptoms, and I was very tired all the time. I wanted to sleep all the time, I couldn’t work fulltime any
more, and I took four months off work altogether, and I became very frightened that I would never be able to get back to work. I really thought for quite a while that I would not get back to work.

(b) Expressions of distressing emotion (74%)

Seventy-four percent of women expressed distressing emotion, which included sadness about losses, anxiety, anger, depression, and many expressions of fear. These expressions of distressing emotion indicate that almost three-quarters of the women interviewed were experiencing a time of transition, with a need for change in their construct systems (Kelly, 1955/1991a). This is supported by further evidence, to be discussed in the next Section, that 70% of women found it difficult to predict what would happen, or was happening to them. If a woman’s existing construct systems are not adequate for successful predictions about menopause, and she becomes aware of the need for change, she is likely to experience the emotions of transition, such as anxiety, threat, fear or guilt (Kelly, 1955/1991a). One result, therefore, for Research Question 3, is that it appears that 74% of the women were aware of a need to reconstrue themselves in relation to menopause.

Some women directly related their emotion to their awareness of change. Fiona was particularly upset, saying menopause was: “An ending of being able to give birth that makes me very sad.” Val was worried; “They decided that, yes, I was premenopausal. I said I wanted to do something about it, I was worried about dementia, I was worried about osteoporosis, I wanted to go on HRT.” Enid’s doctor decided that she required medication for her emotional state:

I said “I’m not depressed,” and they said “no, you’re not but you’re suffering very high levels of anxiety and stress due to the hormonal changes” … And I said I’d try anything, and I tried them, and so that has managed my stress levels
incredibly … And I’ve asked how long I stay on these, and he just says “stay on them,” that’s Prozac, he just says “stay on them.”

Premenopausal women, such as Margo, often expressed anxiety about the future:

There’s an element of fear, because I’m absolutely petrified about hot flushes, and mood swings, and everything else, because I get bad PMT, and I get dysmenorrhea, and I get all that garbage. And I think, well, I hope I’m not an absolute bitch to live with when I’m in menopause.

(c) Expressions of difficulty in predicting what would happen (70%)

This theme includes subsections dealing with aspects of women’s expressions of Inability to Predict and feelings of confusion (Appendix G). Women struggled to anticipate what was happening at the time of the menopausal transition, and many said that they were unable to successfully anticipate changes. As noted in Section (b), if women’s existing construct systems are not adequate for successful predictions about menopause, and they becomes aware of the need for change, they are likely to experience the emotions of transition.

There were other strands to this theme, which intersect with themes of “Conflicting Information,” and “Doctors,” to be reported later. Women reported that an awareness of conflicting information made it hard for them to predict what would happen. Some women’s predictions were invalidated, sometimes by medical authorities, and this left them feeling they could not make further predictions as they were unable to elaborate their own construing, particularly in the medical context. Women had difficulty in making predictions, and therefore satisfying choices, when information was conflicting or invalidating, and they were not able to elaborate their construing. Personal construct theory suggests that if women have difficulty in making predictions, and engaging in, or completing, the cycles of construction, they will not be
able to move to creative reconstruction and will continue to experience the emotions of transition (Kelly, 1955/1991a).

Vera’s response encapsulates the difficulty of prediction: “I didn’t have a clue what was happening, I mean I couldn’t figure it out.” In relation to hot flushes, Nora said: “I didn’t even realise I was going through it, because about three months ago … I complained to the manager where I had worked that the air-conditioning was playing up.” Ellen did not know what was happening, she said “the last 18 months my body’s been doing some funny things.” Sally said: “I don’t really know if I’m in that stage or not.” Cecily remembered that:

What menopause meant to me was a lot of uncertainty about things that were happening to me, that hadn’t happened before … It was a confusing time because I didn’t really know, but it was frustrating, frustrating too. Because I couldn’t meet my own expectations of what I would do. Confusing in that I didn’t know why, and frustrating in just the pure reality of it.

Some women found that their anticipations of menopause were not validated. For example Gwen reported that:

Initially it was confusion, because no one could diagnose that I was going through menopause, and therefore it meant for me a health issue. I thought I had something else. I thought if I don’t have menopause what do I have? And the doctors were basically saying … you’re too young, there’s no way.

Lena was disturbed by the invalidation of her anticipations, and described her difficulty predicting:

I expected that I would just float through this fairly easily, because I just never, never get headaches or things like that. But I got quite a shock, because it wasn’t like that at all. It was actually quite terrible. I had awful hot flushes, something like 40 a day, but almost the whole bed would be wet, I’d have to get
up and change the clothes in the middle of the night. And so after 48 years of having a great healthy life, … it gave me a bit of a surprise that it would affect me … I thought I’d just float through it, like I floated through most other things in life. That I wouldn’t get hot flushes.

Premenopausal women, such as Nan, found it hard to anticipate the meaning of menopause: “Menopause to me, I think it is the unknown in a way. What … the changes will be, what it means.” Anita’s response was similar: “I probably … think of it as being a grievous process that I have to go through, that I don’t understand what is going to happen in that process.”

(d) Awareness of changes to the body (70%)

This theme is included in a grouping of themes dealing with Awareness of Change (Appendix G). Predominantly, women were troubled about possible changes to their bodies at the time of menopause and beyond. The fact that so many women mentioned changes to their body suggests that the majority of women find that they need to revise their constructs about their bodies at the time of menopause. This again suggests, in relation to Research Question 3, that women often reconstrue themselves at menopause.

Some women had a sense of changes that were beyond their control, while others were reconstruing their bodies, and planning actions to maintain a feeling of control. Dora’s anticipation was that she would go through: “A state of watching my bits and pieces of me fall into decrepitude slowly.” Reba anticipated a significant change that she would have to cope with: “A changing body image, and the adjustment that goes with it, and the adjustment that goes with accepting that my skin goes softer, and wrinkles appear.” Sally’s response was similar: “It seems to be a time for women when you’ve really got to work at not going downhill both mentally and physically.”
Weight gain and a changing shape were common concerns. Betty said: “you change shape a bit,” Nora also reported “I have been battling with the middle age spread, and I’m not dealing with that very well.” Michelle’s anticipation was similar: What I know is your figure changes because of the hormonal effect. So in other words, rather than having a waistline of 24 inches, you’ll be getting 30 inches after you’ve started menopause …. I do like to keep a slim figure, and in future what I’m expecting myself to be would be a barrel shape. So that’s something that I have to deal with. So I have actually started to buy pants or trousers that are of elastic type, to fit in to the future shape that I’m expecting in two years.

In the four major themes, occurring in 70% or more of the women’s responses, there is evidence of an awareness of change, difficulty in predicting, distressing emotion accompanying the awareness of the need to change, and difficulty in engaging in, or completing, the cycles of construction, and moving to creative reconstruction and control. As noted earlier, the indication from these themes in relation to Research Question 3, is that more than 70% of the women were aware of change and a need to reconstrue themselves in relation to menopause.

5.6.1.2 Major Themes 2: Occurred in 50-62% of Responses

Eight themes occurred in between 50% to 62% of transcripts, and appear in Table 5 in order of frequency. These themes include construing reflecting negative emotion in relation to issues such as an awareness of changes to the mind or memory, aging and health concerns, but they also reflect constructions of change, such as descriptions of strategies for coping, exploration of remedies such as hormone therapy, and mothers’ experiences, and reconstruction and acceptance. In terms of the personal construct model of menopause, described in Chapter 4, the themes are characteristic of Structural Pattern C: Limitation and Invalidation, but also Structural Pattern D: Reconstruction and Validation.
Table 5

*Themes Occurring in 50-62% of Responses*

<table>
<thead>
<tr>
<th>Theme</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Awareness of Age</td>
<td>62</td>
</tr>
<tr>
<td>Prediction based on mother’s experience</td>
<td>62</td>
</tr>
<tr>
<td>Periods</td>
<td>57</td>
</tr>
<tr>
<td>Strategies</td>
<td>55</td>
</tr>
<tr>
<td>Exploring construing about HRT</td>
<td>55</td>
</tr>
<tr>
<td>Acceptance</td>
<td>51</td>
</tr>
<tr>
<td>Medical experiences</td>
<td>50</td>
</tr>
<tr>
<td>Changes to mind or memory</td>
<td>50</td>
</tr>
</tbody>
</table>

(e) References to aging (62%)

This theme is included in a grouping of themes dealing with *Awareness of Change* (Appendix G). The references to this theme occurred throughout the interviews. Responses to Question 4 “How do you feel about getting older” did not necessarily elicit references to aging in relation to menopause. The question was designed to separately identify women’s meanings of aging, and these responses will be discussed later, in Section 5.6.1.4.

The references to aging were mostly negative, fearful, or expressions of difficulty in predicting aging. The only woman, Margo, who said she could “accept aging as a positive” actually expressed this in the form of denying that she was fearful of a list of negative effects of aging: “It’s not a fear. I’m not frightened of disability or getting old, and ugly, and frail, osteoporotic, and osteoarthritic … I can accept aging as a positive I guess.” An acceptance of aging, however, came from one of the older women in the Study, Tanya said: “I, of course, would much rather be younger, but I’m quite comfortable with being old.”
Zoe’s view was bleak:

Menopause, I think, means the beginning of old age to me. I think in our society there is a bit of a cult of youth and beauty, and so it is a bit intimidating to think of menopause. Because you will not be able to imagine yourself with, or as, an object of desire, in that way that is promoted so heavily, I think, in our society and culture.

Tracy also judged that: “it is linked with an aging process … you wake up in the morning and you look at the wrinkles everywhere … ‘am I going to dry up and become wizened and get a tight mouth that becomes all wrinkled and pussy bum?’”

Many women’s meanings of menopause were related to age. Beth said: “It’s about aging too … you think, if you say that, [being menopausal] you’re going to tell people how old somebody is.” Gwen had a similar concern:

It was the fact that aging was going to speed up and that was a great concern.

So in one way I was happy that I was menopausal, but in another way I thought “why did this happen so young? … only old people are menopausal.”

(f) References to, and predictions based on, mother’s experience (62%)

Women looked to their mothers to assist them in anticipating menopausal changes, a finding that has been noted by other researchers (Holte & Mikkelsen, 1991b). McQuaide (1996), for example, found that women wanted to be prepared for midlife so as not to have a “breakdown ‘like my mother did’,” (p 138) and that this was a common fear.

The responses captured by this theme can be seen as attempts to engage in circumspection, by gathering information to improve prediction. I therefore included this theme under the heading of Exploration (Appendix G). These responses also constitute some evidence of the ways women construe other people’s constructions of menopause, the subject of Research Question 2.
Some references to mothers were positive, others negative, while other women regretted that their mothers would not talk with them about menopause, as they felt that this increased their difficulty in predicting what would happen. Dawn thought her own experience reflected her mother’s example: “A lot of that was my mother’s philosophy of ‘it just happens to everybody’.” Brenda based her prediction on her mother’s experience: “I don’t feel that I’m going to suffer anything major. My mother never really experienced bad symptoms during menopause.” Anita, however, said that: “In my family, my mother never discussed it. It was something that was not, … it was never discussed as to what was going on.”

Women whose mothers had had a difficult experience of menopause expressed some anxiety in their own anticipations. For example, Karen said: “My mother had a little bit of a hard time, and I believe that it follows from mother to daughter quite often, that it’s a similar pattern. So that’s not looking good, but I just don’t think about that.” Iris also based her meanings on her mother’s descriptions, and expressed feelings of loss as she experienced menopausal changes:

Years of my mother and other older women who might have … phrased it in terms of loss … helped me to interpret that as things that they had seen passing from their lives. Sport, that they may not have been able to play as vigorously, physical activity, loss of a figure, loss of physical attributes, that sort of thing has coloured my view.

(g) References to periods (57%)

It is not surprising that there were many references to periods, since the meaning of menopause is the cessation of the menses. The ending of the nuisance and expense of periods was often cited by women as the main advantage of menopause. For example, Joanne said: “I couldn’t wait for it to happen, because that means you wouldn’t have to have periods anymore.” Lena responded “the only plus to me seems
to be that you don’t actually have to cope with your periods, and all the sort of emotional ups and downs that go with those.” Betty thought the advantage was: “Not having to stock up on tampons or pads at pharmacies.” For some women, menopausal change was heralded by unwelcome changes in bleeding. Enid reported that: “My bleeding became erratic and I was bleeding, not a lot, but more consistently … so menopause has not been, the idea of menopause has not been too pleasant.”

(h) Strategies for dealing with menopause (55%)

This theme is included in a grouping of themes dealing with Construction of Change (Appendix G). Women reported strategies that reflected the choices that they made in dealing with menopausal symptoms. These included both physical and psychological approaches. This Section presents responses relevant to Research Question 5, which asked what choices women made in dealing with menopause.

Some women made choices such as changing their lifestyle, or using alternative remedies. Enid’s approach was: “Changing my diet, changing my habits around coffee, and alcohol, and that sort of thing”; similarly Lisa said: “I’m just drinking lots of soy milk.” Other women went a little further. Michelle, for example, was actively preparing for menopause: “I’ve started to cook all these Chinese herbal medicines basically to help to build up the body. Get myself ready for the oncoming of menopause.” Imogen used herbs to tackle the problem of tiredness: “waking up in the night with minor hot flushes, and not getting a proper sleep always makes me weary, and I went to my herbalist who gave me some herbs, and the herbs enabled me to sleep.” Other women, such as Xanthe sought medical assistance: “I thought I better go and check, which is why … I had the blood tests done.” Clare, a diabetic, looked to a physical and spiritual system to help her: “the spiritual aspect of Ikedo will become more and more a part of my daily existence.”
There were other women who attempted to reconstrue the symptoms of menopause to develop more positive meanings. Nora reported that: “I’ve got a colleague … saying to me ‘power surge, power surge’. And I say ‘yes, power surge’.” Ellen said she had had to develop strategies for loss of memory: “you develop strategies … when you’re talking with people, and try and think of other words desperately … or changing what you were going to say mid-stream, because you know you’ve lost that combination of words that goes with a particular thought that you’ve got, and I found that quite distressing, that’s a huge problem for me”.

Gwen took a very creative approach: “I remember when I was working with women who were all going through menopause. I formed a menopause club, and you weren’t allowed in it unless you had hot flushes, and it was like a support group.” Two other women’s ideas reflected a wish that strategies could be adopted on a much larger scale in the community. Therese had an idea for a “grey Mardi Gras,” to celebrate aging, and Sally proposed the idea of menopause parties, as she regretted a lack of opportunities to find out about, or celebrate menopause:

You do not get very prepared for it … I think that what is bad about it is that there are not menopause parties, like twenty-firsts and things … it is like a little silent creature that creeps up on you, and you start to notice symptoms.

Some women tried a variety of approaches, trying both medical and alternative remedies. Therese expressed a common struggle to find a solution:

My doctor had a couple of times suggested going on the pill, and I had always said “No,” because I didn’t want to have artificial hormones in my body. And then more recently … she’s suggested it to me again as a way of coping with this process. And so that’s what I’ve done. So I’ve actually solved the problem.
For other women, such as Dawn, it was a battle to find an acceptable remedy that did not invalidate strongly held constructs about self-reliance, and natural processes:

I didn’t want to go on any sort of HRT treatment. I wanted to try and deal with it myself, and I did try … I tried a few things before HRT but I didn’t go to a naturopath and sit down and talk to someone, I just tried some tablets that the naturopath at the health food store gave me. I tried that for about 3 or 4 months and it didn’t seem to work … I was probably depressed about it maybe … and I hadn’t even at that stage found a tablet or found anything to relieve most of the symptoms either. And it was in the middle of that that I thought, I’ve got to handle this.

(i) Hormone replacement therapy (55%)

Responses that referred to hormone replacement therapy are relevant to a discussion of women’s choices, and therefore Research Question 5. Fifty-five percent of women mentioned hormone therapy, often in conjunction with expressions of anxiety about the implications of its use, such as those in the preceding quotations, at the end of Section (h). As noted in Section (c), women had difficulty in making predictions, and therefore satisfying choices, when information was conflicting or invalidating, and they were not able to elaborate their construing. Again, as I observed in Section (b), when a woman’s existing construct systems are not adequate for successful predictions about menopause, and she becomes aware of the need for change, she is likely to experience the emotions of transition.

Geraldine’s reaction was: “I find it quite a worry, menopause … I’m quite worried about it because of the impact … I find sort of all that stuff about HRT so incredibly confusing and worrying.” Alice’s construing about herself was invalidated on a visit to her doctor, when she interpreted a reference to hormone replacement
therapy as a sign that she was aging: “I went to a GP and she said to me … I’d really like you to think about HRT and I said ‘oh well, hang on’ - first I’d even thought about it before this year.”

Vicki’s reaction to the possibility of hormone replacement therapy was a feeling that life was not fair to women:

It’s a pain to have to be always reliant on that pill everyday, like we have always had to be. Either on a pill to stop having babies, or now we’re on another one, and I think sometimes it’s a bit of con, but I have certainly tried to break off it and it doesn’t work.

Other women found that hormone therapy improved their lives. Yolande reported “I’m … generally feeling better, and I don’t know whether that is now because I am on HRT or not.” Olwyn was pleased to have a problem rectified: “The doctor said ‘you … are menopausal, that is what has caused the calcium problem’, and so I went on to HRT, low dosage, and it corrected the calcium problem, and … it didn’t feel any different to me.”

(j) Acceptance and reconstruction (51%)

This theme is included in a grouping of themes dealing with Reconstruction (Appendix G). Approximately half the women interviewed expressed some acceptance of menopausal changes, either in their predictions, or in their reports of menopausal or postmenopausal life. This proportion is interesting taken in conjunction with the proportions quoted in the preceding Sections. There is an obvious overlap between 51% of women expressing acceptance, and 74% of women expressing indications of distressing emotion. With reference to Research Question 3, it provides further evidence that women were indeed engaged in a process of moving to reconstruction. Emotion accompanies a need for change, but acceptance indicates some degree of reconstruction.
Women’s comments coded under this theme ranged from the relatively flippant to more thoughtful reconstructions. Kim was philosophic: “I think shit happens. Just try and plant fast growing trees, so that you see them.” Irene had reconstrued a little more of the future: “I still think, you have to grow old gracefully. You change your hobbies … you can still remain mentally active, and you just change what you do. You don’t ski ‘black’ runs, you ski ‘blue’.” Clare said: “I reckon that if I just get away with hot flushes, I’m probably doing real well, and if I’m not having periods that’s great.” Winnie’s reflections revealed more comprehensive reconstruction of her experience:

I suppose part of the way I got through it was to think this is … a passage; it’s a kind of a watershed. It’s a period that if you sit still … and let it happen and survive it … I felt that would make me stronger, and then more able to cope with the next stage of my life, so I just had to keep really having faith in that no matter how depressed I got.

Rilda had a positive anticipation of life after menopause:

It’s another facet of your life, and it’s a new stage, and I think it’s got its bonuses. You don’t have to be paranoid that you’re going to walk down the street and all the construction site will whistle, and so you sort of think ‘excellent’, so I think it has a lot of pluses.

Reba had thought through her feelings about her stage of life and successfully construed herself as an older woman:

I’ve got no desire to have to fit into this young model of a woman or whatever, it just would be totally wrong. I feel perfectly comfortable with the age I am, and I feel a very much part of my own age, very much part of my peers, and of the world that I grew up in, and that I have experienced...I couldn’t imagine to be any different, I wouldn’t want it to be any different.

Ann had also successfully reconstrued herself:
There is, I think, a period where you start to think of yourself as older and aging, where it is possible to celebrate that growth of a sense of personhood, a sense of being competent in the world, a sense of being in control of your life a bit, that sort of thing. I think that that coming into full maturity, in a sense, is a celebratory time.

(k) Medical or health issues (50%)

Fifty percent of women mentioned a medical or health issue as one of their meanings of menopause. There were also a small number of women reported medical or health problems, which complicated their experience or expectation of menopause. Rilda told a disturbing story about losing her hearing as a result of the hormonal changes in pregnancy. This shaped her anticipations of menopause: “I suppose for me it’s a panic because I have got this thing called otosclerosis, which is with my hearing … my paranoia is in menopause it will get worse.”

Clare’s existing medical condition overshadowed her expectations of menopause:

I guess the other thing I worry about in terms of getting older, is whether my diabetes will hold out to get much older basically. Getting older is more related to worrying about whether I will make it past, I don’t know, 50 probably … I think probably the bigger concern for getting older probably is diabetes, the complications.

Ann’s experience of menopause was unusual: “menopause happened for me in a really untypical way, and in fact I was 26, and had cancer at the time and I was radiated. My low abdomen was irradiated for the cancer and that sterilised me”.
(l) Awareness of changes to mind/memory (50%)

This theme is part of a group of themes grouped as an Awareness of Change (see Appendix G). Many women expressed anxiety about changes to the functioning of their minds, either in terms of unwanted psychological changes, a loss of capacity, or memory loss. Enid’s response was: “It means having fuzziness or confusion in my thinking … I suppose it means being … what I would term as being too emotional, you know, crying easily, being hurt easily.” Gwen said: “You don’t think as clearly, you forget things, and you forget where you put things. You have them in your hand, and then they’re gone, and you think where the hell is that?” Fran reflected that: “I feel dull and heavy, my head feels heavy and … I’m not thinking as well as I could, I’m not very sharp.”

Sally expressed fears:

I have been a woman who had the untidiest desk in the world, but always know where to put my hand exactly on the paper that I want, but suddenly could not do that anymore. So I was having, severe pre pre-dementia shadows, pre-dementia shadows, so I thought “I’ve got to look at this.”

Michelle’s anticipation of menopause was not very hopeful:

I know that the temper, or the personality, or the temper of the woman changes after menopause … they are very impatient and cranky. They get forgetful, their memory loses [sic], all these bad things.

5.6.1.3 Minor Themes: Occurred in 36-49% of Responses

Twelve themes occurred in between 36% and 49% of women’s responses, and appear below in Table 6. They represented a variety of constructions about menopause that again included both distressing, and more constructive meanings. While there were concerns about loss of role or loss of control, references to childbearing or lack of fertility, and descriptions of stigma or taboos, there were also expressions of relief, and
a conviction that menopause meant no change. Some women saw menopause as a significant time or marker in their lives. This group of themes also included descriptions of interactions with doctors, and family. In terms of the personal construct model of menopause, described in Chapter 4, the themes are again characteristic of both Structural Pattern C: Limitation and Invalidation, and Structural Pattern D: Reconstruction and Validation.

Table 6

Themes Occurring in 36-49% of Responses

<table>
<thead>
<tr>
<th>Themes</th>
<th>%</th>
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<tbody>
<tr>
<td>Marker or significant time</td>
<td>49</td>
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<tr>
<td>References to work</td>
<td>49</td>
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<tr>
<td>Loss of role, or loss of control</td>
<td>47</td>
</tr>
<tr>
<td>Relief</td>
<td>47</td>
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<tr>
<td>Fertility</td>
<td>44</td>
</tr>
<tr>
<td>Visits to doctors</td>
<td>43</td>
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<tr>
<td>Stigma or taboos</td>
<td>42</td>
</tr>
<tr>
<td>Family</td>
<td>39</td>
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<tr>
<td>No change</td>
<td>38</td>
</tr>
<tr>
<td>Discussion</td>
<td>38</td>
</tr>
<tr>
<td>Natural process or therapies</td>
<td>36</td>
</tr>
<tr>
<td>Information conflicting or limited</td>
<td>36</td>
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</tbody>
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(m) Menopause as a marker or significant time (49%)

This theme is included in a grouping of themes dealing with Awareness of Change (Appendix G). Women frequently referred to menopause as a marker or
significant time that signaled a new phase in their lives. Wanda said: “I suppose a change in your life in many ways, like moving into another phase.” Other women, such as Pat, felt the same: “I think it is definitely a significant stage in your life, that I would only compare with teenage pre-adulthood or adolescence, where, I mean, you have got changes in your body.” Karen reported that: “there’s a copy of the Germaine Greer’s book that’s handed around when it’s your time, so I’m looking forward to that rite of passage when I actually receive the book.”

For some women the significance of menopause was in the ending of their reproductive life, and the implications this had for their role as a woman. For Harriet it meant:

“It’s the end of your … years as a woman, but I guess that women were originally put here predominantly to have children, whether we choose to or not is another story, and maybe that’s the end of that phase of our lives.”

Nancy also said:

The first thing that came to my mind is that it is quite symbolic … because I do not have any children. So I think that menopause is quite a symbolic sort of thing, even though it is long before that that you become clear that you are not going to have kids … it is just quite symbolic of aging, moving into … that next group of women, and facing a different part of your life, the second half or whatever.

Reba had a vision of a new role:

I’ve always had the image of the crone when it comes to menopause. I always think that’s the time when as a woman I’ll move on to a new role, away from the immediate constant care and nurturing for the next generation (which won’t happen in my case probably. I’m still busy with my children, because they’re still so young now) and moving into a phase, in my imagination anyway, it’s the
phase where I just get that little bit more independence from the judgement of others, from having to fit into a given role. I always feel that menopause is like the beginning of a new chapter where I just sort of enter a new cycle where different rules apply to some extent ... I don’t have a name for it. No it’s just a crone, it’s sort of the cycle of the crone.

(n) Work (49%)

I was particularly interested in employed women’s experience of menopause, as noted in Research Questions 1, and 5, in Section 5.3. While responses to these Research Questions are found throughout the themes, this section deals in more detail with women’s concerns in the work environment, and the choices, such as taking medication, that they made to assist them to continue working. Overall, 48% of the women described the difficulties of experiencing menopausal symptoms at work. When premenopausal, perimenopausal and menopausal, and postmenopausal women were considered separately, the percentage of women raising concerns about difficulties at work was, as could be expected, lower for the premenopausal group. The percentages were premenopausal = 37%, perimenopausal/menopausal = 60%, and postmenopausal = 54%, that is, more than half of the women who had actually experienced menopause volunteered that they had perceived some difficulty at work.

Hot flushes often caused women embarrassment at work. For example, Deb told of how she might be: “participating in the meeting, and then suddenly the flush, and you start sweating, and you think everyone must be looking at you.” Fran shared this concern:

Mostly it was just the hot flushes, and they’re okay on their own, but it’s when you’re at work and you’re visibly, there clearly is something wrong with you, that you’re uncomfortable, and people comment on it ... and it’s not always
appropriate to say “I’m having a hot flush, just ignore me, pretend I’m not here.”

Sleeplessness due to hot flushes also proved a problem for women. Prue’s experience illustrates the difficulties of women who continue to work despite severe symptoms, and coincidentally the types of stereotypes that are perceived to operate in the workplace:

Being kept awake with hot sweats - even with the highest dose of HRT. It was still so intense that sometimes I’d only get ½ an hour, at the most 2 hours a night sleep, and that did change my life a lot, in that I didn’t feel that I had the energy to get up and continue an incredibly energetic full-time job … I couldn’t have had sick leave, or given that as a reason. I was not going to play into their expectations of hysterical woman, and “God we don’t want a woman in our discipline anyway” … That was stressful.

Gwen also had a difficult time:

I would get up in the middle of the night and have a bath, and I’d fall asleep in the bath because I would be so exhausted. I couldn’t behave like this when I was away on a conference. So I went on it [HRT] straightaway … Initially it was like they [hot flushes] would go for half an hour, and just zoom up through your body, this temperature. And your face would be burning and you’d be pouring. I remember sitting in a meeting discussing something and one of the other women, who I have never met before, just looked at me and turned the fan on, and put it right on my face, because she could see that I was having a lot of trouble. And I mean you worry about that, you worry about what other people think while you are sitting here in discomfort. And you try and also participate in a meeting that’s really important.

Ellen felt as though her mental capacities were under threat:
The worst part for me was being at work and losing concentration … I can remember … being in a meeting and thinking I’ve just I’ve lost it, I’ve just totally lost the thread of what’s happening. I couldn’t remember what people said, and then after a while it would go, but it was just a weird sort of combination of embarrassing and distressing. And it wasn’t really until other people there would have said funny things like “is it hot or is it just me” that I realised other people were going through it … I would have had to have left work if I’d not been taking medication.

Cecily also felt her capacity to work was affected:

I thought, what is this strange feeling because I haven’t had it before … because it was affecting my ability to do my job, to my own expectations. I think I was still doing well enough to satisfy the boss, but I knew that I wasn’t getting through the same amount of work … I just had a general feeling that my effort wasn’t very good, that it had gone down, and the amount of work that I was pushing through on a day to day basis was getting less. My energy was low.

Other women made a decision to use medication to allow them to continue to work to their previous capacity. Zara said:

I made the decision, when I was still working, that I want to continue on the contraceptive pill simply so that I wouldn’t have menopause while I was working, and that was because I thought that it … might make changes to the way I interacted with people while it was occurring.

(o) Loss of role/ loss of control (47%)

Feelings of loss took many forms. Women talked about feelings of loss of bodily fitness and capacity, loss of opportunities for enjoyed activities, but also loss of important roles, such as that of mother.
Fiona, in particular, was very distressed about the ending of the child-bearing phase of life, and expressed a lot of grief in her interview. It seemed as though she was experiencing fear, in the personal construct sense, as her construing of menopause seemed to mean a significant assault on her construing of her role as a mother. Fiona showed such distress that we discussed finishing the interview, and I ensured that she subsequently had an appointment to see a therapist. I quote a brief example of her words to indicate the direction of her feelings of loss: “I think it means somehow an ending of something, and I’m not sure what else …an ending of bleeding, an ending of being able to give birth, that makes me very sad … my children are older and leaving.”

Joanne also felt some grief, and recognised her difficulty in constructively construing the future:

It’s like mourning … I’m still the same person but my body isn’t, and things are changing that I don’t want to. And the other thing that’s very sad for me personally about getting older is that … having had own children very late in life, what I really think about, is the fact that I won’t be able to see them grow up, and maybe have their children, as much as if I would have had children younger. So that’s a very upsetting thing for me.

Dora’s feelings of loss related to her energy levels: “Feeling that I no longer have the energy that I used to have, to do all the physical and mental things that I enjoy doing, and all the social activities that I enjoyed, as part of an active life.”

Stella’s emotion and feelings of loss were related to her recognition that she needed to reconstrue herself:

I don’t mind getting older, only that I realise how quickly life’s gone by. I hate that. I hate to think that. Its because I thought once you got to 55, 56, your life was over and you should be retired … mentally I don’t think any older but I am
feeling it in that I get extremely tired, I’m fighting tiredness all the time, and I hate that.

The meanings of menopause for Iris included a strong sense of loss, and threat to her constructions of herself:

It’s the huge changes that would come into life through menopause … in terms of what you’re losing, losing fitness, losing physical looks, losing contact with the sorts of things you’ve done in other parts of your life. And I think there’s a sort of losing competence, so it’s a loss, it’s a feeling of loss.

The meaning of menopause as a loss of role, with its associated threat, was also reflected in premenopausal women’s comments. Hilda said: “I think probably one of the main messages I’ve picked up is about the HRT, and about probably aging, and loss of beauty, and loss of youth, and loss of grace.”

(p) Feelings of relief (47%)

When women thought about what was good about menopause, it was common for their construing to be about the relief from menstruation and contraception that menopause would bring. A move towards acceptance or reconstruction was most commonly expressed in this form. Often women saw this as the only good thing about menopause.

Michelle said: “The positive side is no more worries with the period, no more hassles with that because … when I menstruate it’s very heavy … there’s a huge loss of blood.” Tanya remembered: “oh it was lovely, the end of awful contraceptives and all that, it was lovely.” Marj predicted: “having no periods, that’s really what I’m looking forward to.” Pat remembered the feeling of relief after a trying time:

The bad horrible thing is … the heavy bleeding, and the pain, and the headaches … but when it stops “hallelujah, it’s great” … that’s traumatic if you’re going through a really bad time, and then it stops, and it just isn’t there any more …
it’s just wonderful, you’re almost feeling a wonderful sense of freedom again and wellbeing.

Ursula, an older woman, said:

To me there was only one sense, “whacko that’s one little inconvenience out of the way … Good, no more worrying about calendars, good” … Relief. It was just the inconvenience was over. Didn’t need to worry about it … you didn’t have to sort of check a date before you did anything anymore … And another thing, it meant that I didn’t have to go through all that, all the rotten things that happened to me in my life. I can start again. So it was really a relief in every respect for me.

(q) **Fertility or child-bearing (44%)**

Fiona experienced menopause as a threat to her role as a mother, and her feelings about her loss of her child-bearing role have been quoted in relation to loss in Section (o). For other women, menopause was a time to reassess their decisions about **child-bearing**, to engage in, or revisit the decision-making cycle relating to this issue. Harriet felt that there was a loss of choice, and was struggling with that invalidation: “it obviously means the end of your child bearing. Not that I had any particular desire to bear children, but it was kind of nice to have the option, and now it looks like it’s been cut off, and maybe that’s a bit depressing, disappointing.” Dawn found that she had to rethink an earlier decision:

I talked to my husband … and it was only after I really talked through all the children bit … this is a second marriage, even though I knew before we got married that we weren’t going to have children, because we talked about it before we were married, I almost had to revisit that, because I was now getting to the stage where I couldn’t ever have children, and so I thought I had to deal with that, and I think we did. And I’m not sorry now at all.
Dawn also talked about her efforts to reconstrue herself in a new phase of life. On a philosophical level, it’s really been good because it’s been almost like a benchmark … It’s caused me to do a lot of thinking, almost like the end of an era or something, and it’s given me a chance to really look at the fact that I didn’t have children, and did I wish I had, and all those sorts of thoughts have happened … instead of getting upset about it, because at times I have been, I try to think, well okay this is now the beginning of the next phase, and that’s the stage I’m at, at the moment.

Other women’s construing varied. Ann, who became infertile after having one child, said: “I can’t say that I had a moment’s angst about becoming infertile.” Gwen, who had chosen never to have children, had a similar view: “The whole idea of not being able to have children didn’t worry me at all.” Lena had a positive construction of the future: “obviously it also means that you can’t have children anymore, but having now had children, that’s also something to really look forward to.” Margo also sounded as though she felt validated in her choices: “There’s all stuff about family and so on, being a dyke means that I don’t have children, so I don’t have that sort of thing about letting children go out of my life.”

(r) References to doctors (43%)

This section, together with the following two sections dealing with Stigma and Taboos, and Family respectively, provide some information relevant to Research Question 2, which asked how women construed other people’s constructions of menopause.

Nearly half of the women referred to doctors, and constructions of what doctors had said, or meant. Women’s experiences with their doctors varied considerably. A few women reported that they were satisfied with their doctors, Alice, for example, said: “I have a very good GP.” One woman, Harriet, thought she could do without a
doctor entirely: “I thought I don’t need to go to a doctor, I can self-diagnose, that’s what the internet’s there for.” Most women were like Hope, however, who had not yet found a suitable doctor, and said: “I think I need a doctor that I can talk to.”

Many women told stories of frustration, medical mismanagement, a lack of understanding, and a search for help. Prue’s story of a very difficult experience in a medical context has been presented in Section (a). Vicki related a particularly callous example of an interaction with a doctor:

Checking with the doctor, he says “well, what do you want, fat arms?” Which apparently happens if you are not on the hormone replacement. You know, you age more quickly. He thought you age more quickly, and that it [HRT] would help me stay younger. And I thought, “oh that sounds good idea to me,” so stayed on it.

Other interactions were unsatisfactory, with women feeling unable to communicate successfully with their doctor. Many women appeared to construe the medical profession’s constructions of menopause as unhelpful. Vera’s case is an example of this.

I went to a local doctor … and she said well it sounds like menopause to me … she did … two estrogen tests, … and she said that I would obviously have to go on hormone replacement therapy … and I said “well I don’t want to discuss that so I will come back and get the tests.” My estrogen levels had … came back as post menopausal, so she said: “well you have definitely got to use the drugs,” so I just said “no,” and never went back to her.

Pat also had a difficult experience with a doctor who did not respond appropriately to her feelings:
You go to a … male gynecologist, they’re ready to dump HRT … on you. But in a way you want more help with understanding what you’re going through … so I just walked away from the gynecologist.

\textit{(s) Stigma and taboos (42\%)}

In this section I build on the previous section in providing a picture of how women construed other people’s constructions of menopause, the issue addressed in Research Question 2. It was an interesting facet of this research to discover the taboos and stigma that still surround menopause, despite the publicity given to debates about associated health issues and treatment.

Clare’s view was: “There’s a social thing around getting to 40, and then I guess there’s more getting to 50, a stigma, what have you done with your life? What haven’t you done?” Rilda also referred to negative perceptions of menopausal women: “I’m getting towards 50, and … like that ad on TV … there is a sort of perception that as you become menopausal you’re either going to become totally feral, or you are totally backward, or there is going to be some problem.”

Vera experienced an invalidation of her construing of herself that reflected an internalised feeling of stigma:

I actually found myself ashamed of it you know, that I was having this at this age … it was all right to have it at 50, but at 43 it was sort of … I tried to tell people about it, and of course nobody had any response at all. They thought it was perfectly all right, but I didn’t.

Joanne confirmed this internalised taboo: “Women will share their childbirth stories, but they won’t necessarily share their menopause stories, unless they know you well.”

Other women’s meanings of menopause provided some explanation of why women might be reluctant to acknowledge their menopausal status. Marj observed: “I
must say, it is often a label put on women, ‘that woman is menopausal’, and somehow all her behavior is somehow explained because she is going through menopause.”

Stella had experienced harassment at work in relation to menopause:

I don’t like it the way people make a joke of it and sling off - particularly men. If you are having a bad day they will probably say … “put your patch on.” Or they will even say about themselves “oh I better put patch on I’m having a rotten day.” So I suppose it’s like young boys slinging off at girls when they first start to menstruate … They think it is joking but it hits home, doesn’t it? … People make assumptions … “just ignore her, she is a stupid old bird, she’s having hormone problems” … That’s probably why women don’t talk about it, it’s the joking … it’s not understanding why you’re getting all hot and flustered.

(i) Family (39%)

This section adds to an understanding of how women construed their own experience, as well as providing another dimension to the picture of how women construed other people’s constructions of menopause. The theme mainly reflected women’s concerns about the effect their menopausal experience had, or would have, on their partners or family. I noted earlier, in Section 5.6.1.1.(a), that women were attempting to continue their normal lives, even in the event of quite severe symptoms. It appeared as though women did not feel able to put their own needs in the forefront of their lives. In the case of employment this may have been from economic necessity, or it may have been from an unwillingness to let a “natural process” disrupt their lives, but in some cases, it may also reflect a tendency of women to focus on other people’s needs.

Yolande clearly experienced some invalidation as she became aware of menopausal changes, and she was anxious that menopausal experiences might be too much to cope with in addition to mothering. She said: “I was thinking ‘my God I’m too
young for this’ to start with, and don’t want to deal with this right now, because it was around when [her son] was … having all his dramas and also Higher School Certificate.” Cecily reflected: “When I was down, I was tending to take it out on my husband, which I think a lot of us do, and he’s the only unfortunate at home.” Dora realised she had not been tolerant with her partner and was conscious of the implications for her own experience:

I feel in a relationship … it’s important to be conscious … if it’s having effects … changes that you have to be sensitive to. I was very intolerant in the early stages with [partner’s name] because I just didn’t understand. Apart from everything else I didn’t understand why the change was so extreme.

Michelle’s anticipations of menopause were worrying:
I know that the temper or the personality … of the woman changes after menopause … They are very impatient and cranky. …So I thought “oh these are all the things that my husband will have to put up with, on top of what he has to put up with now.”

Xanthe was construing the future, and reflecting on what the changes would mean for her living in a multicultural household:
I think there’s a different attitude towards it in this culture, independence is valued, whereas in the relationship that I have, interdependence is valued, so you’re not on your own to sort out your problems, but you’ve also got to be there too. You’re expected to have your experiences, and to use that knowledge to keep on assisting. It’s not like you’re coming to the end of your life, and you just finish everything, and get chucked out … it’s a cultural thing.

(u) No change (38%)

A significant number of women, more than a third, reported that menopause did not mean any changes for them. For example, Betty remarked: “I don’t feel that much
different than I did when I was about 35.” Alice said: “It didn’t mean anything to me.”

Tanya also said: “Actually it did not mean anything, it sort of came and went. And I did not realise what was happening until a fortnight or so, and I said to my husband ‘I didn’t have a period this month’.” Zara’s prediction was: “I don’t feel that it’s going to alter my perception of myself in terms of being a woman, or anything like that, so I don’t have any hang-ups about it.”

Some postmenopausal women remembered menopause as insignificant. Lee recalled that:

I realised that it had passed, and absolutely nothing had happened to me. I thought, “well, what about that,” and I spoke to the doctor about it, and they said “well aren’t you lucky” …It was, I must say, almost a non-event.

Ursula’s experience was similar, and her negative predictions were invalidated when she experienced a trouble-free transition:

It was a case of … here today and it was gone tomorrow, and I missed it, and I thought, “oh isn’t that nice” …I didn’t have a hot flush, I didn’t have anything. And I had heard all these stories of stuff that happens … So I didn’t need to go to doctors and I didn’t get any … hormone treatment, that they are giving them today.

(v) Value of discussion (38%)

Women who were able to discuss menopause with other people talked about how helpful it was. In personal construct terms, discussion not only provided reassurance and support, but it also assisted women to predict, and presented women with opportunities for circumspection, enabling them to move towards choice and control in the decision-making cycle. The women who had had this opportunity worried about women who might not be so lucky.
Clara’s view was: “What’s always been good about working with lots of women is that the conversations happen very publicly, and so you get to hear what it [menopause] might be about, or not, and that there are huge variations in it.” Joanne also found discussion helpful: “I have friends who have gone through it, and some of them have … talked about it quite openly … which is nice to hear about those things.”

Olwyn’s advice to other women was: “Talk to other women, a whole range of them, not just one, and also your own mother if possible, because you know then you’ll have some expectation.” Deb advised: “I’d say to make sure you get a modern thinking doctor. But, also, if you’re isolated and not able to talk to anyone about it that would be quite horrifying.” Xanthe also worried that it might not always be possible for women to discuss their experience: “if you’re in an environment where you’ve got support … you can actually talk to the people around you, that would be wonderful. If you are in an environment where you feel you’ve got to cover up what’s happened, then it’s different.”

Ellen, who worked with a number of women in midlife, recalled that:

I realised other people were going through it. That actually made it a lot easier … not to get through, but to cope with, because you could talk about the symptoms, and it felt a bit easier knowing someone else was going through it.

Gwen thought that a predominantly female environment was important: “I think other women are more sensitive, and just have more empathy with your odd behaviour, than what males could do.” Vera, a community worker, remembered actively trying to reconstrue menopause in a positive way:

Listening to other women … sharing their aspects of the experience. What we came up with was that lovely twisting of words, if you look at menopause you have got “me no pause.” … we created a political framework around it, “me no pause,” so even if you had a shit of a time, you were not prepared to let it
dominate your life. And that was terrific for some women particularly, but it was … good for me too, for us to talk about it, and rethink it in terms of its normality.

*(w) Natural process/therapies (36%)*

This theme covered references both to menopause as a natural process, and to natural therapies. Some passages referring to these therapies have already been quoted in Section *(h) Strategies for dealing with menopause*, and are similar to Nora’s already noted response: “I’ve taken some Chinese herbs.” Sometimes women found it difficult to manage the interface between complementary therapies and formal medicine. Olive recounted her disappointing and invalidating experience:

I actually went to a holistic medicine person … I was … trying to avoid taking any sort of tablets that I didn’t have to take…. she had this cream … it was a supposed estrogen cream, that you could rub into your breasts. It had quong dong [sic] … and various other things … I remember going to my doctor, who’s a male, and telling him about it, and he said to me “look, if that sort of thing worked, I’d be a really rich person … and it doesn’t work” and that sort of shattered me, because I thought I’d be able to cope.

Other women referred to their struggles with their construction of menopause as a natural process. Vera, for example, said: “I had a discussion with myself, and I said this is perfectly normal, and you know there is nothing to carry on about.” It became a struggle for some women, such as Dawn, to validate the construction of menopause as a “natural process”:

I wanted to be able to deal with it [menopause], because I thought I was very fit and healthy. I weighed less than I do now, I was exercising 4 and 5 times a week … I thought I should be able to do that, and knowing that it’s a natural process that everyone goes through, all females go through. I think it’s just an
expectation that I had of myself, that it was a natural process so why couldn’t I handle it without anything else … but it was just that there were so many side effects that I didn’t expect.

The issue was different for some Aboriginal women. Currently Indigenous women’s life expectancy in Australia is 61.7 years (Cunningham & Paradies, 2000), close to 20 years less than the life expectancy of all females in Australia (Australian Bureau of Statistics, 2000). Fran, aware of the high mortality rate, said:

At the back of my mind I keep saying it’s a very natural thing, and people since time began have been going through this … but then I’m also thinking that people were often dead by this age. They weren’t around to experience these things, so in a way it’s a kind of new thing we’re going through.

(x) Information conflicting or limited (36%)

Women reported an awareness of conflicting information. For example, Cecily said:

Conflicting information, I think one of the bad things about it was that are so many different opinions about treatment, there are so many decisions that you have to make, whether to go on HRT, will you not … So I think that adds to the stress. That it’s not possible for anybody to say absolutely, “this is the right thing for you.” You have to make your own decisions, so making those decisions just adds to what you’re starting to feel physically. So you’ve got a little bit of mental anguish with the “will I, won’t I.”

Themes that occurred in 35% or less of transcripts are not presented here but are shown in the full list of themes, and their frequency of occurrence, in Appendix H.

5.6.1.4 Summary of Responses to Interview Questions

In this section I examine the themes that occurred in responses to individual interview questions. The themes that occurred in responses to Question 1, “What does
menopause mean for you, the good things and the bad?,” were consistent with the pattern of themes discussed in previous Sections, and were predominantly negative. I tested the correlation between ranked themes in women’s responses to the eight interview questions using Spearman’s Rank Order Correlation. Results showed that the strongest correlations were between responses to Questions 1 and 3, \( r(52) = .71, p < .01 \); Questions 1 and 6, \( r(52) = .66, p < .01 \); and between Questions 3 and 6, \( r(52) = .65, p < .01 \). Question 3 asked, Does menopause mean changes in your life?,” and Question 6 asked “What is bad about menopause?”

The relationship between responses to Questions 1 and 3 reflects women’s constructions of menopause as meaning change, changes to the body, and unpredictable symptoms. The relationship between responses to Questions 3 and 6, indicates that the changes that women predicted in response to Question 3, were construed negatively.

The themes that occurred in responses to Question 2 show that mothers were, as discussed in Section 5.6.1.2 (f), a key figure in women’s predicting and construing about menopause. It is interesting that references to stigma and taboos occur most frequently in response to Question 2, “What do you think menopause means to other people?” Women were construing other people’s constructions of menopause, rather than their own, as limited by stigma and taboos. The anticipations based on those constructions, however, shaped women’s behaviour, and often resulted in distressing emotion, as women felt invalidated in their professional lives if they perceived that their menopausal symptoms were observed by others.

The responses to Questions 3 and 7, asking about possible changes in women’s lives, show a concern with changes to the body, with approximately a quarter of women, in each case, expressing distressing emotion. Responses to Question 3, which asked “Does menopause mean changes in your life?” show that 19% of women thought that menopause would not, or did not, mean change. Responses to Question 7,
however, which asked “Has menopause changed the way you think about yourself?” reflected a concern with aging and other losses.

Responses to Question 4, “How do you feel about getting older?” were mixed. While 48% of women were concerned about changes to their bodies, and 42% expressed distressing emotion, 32% of women referred to an acceptance of aging, and 19% described some constructions of the future. A comparison of the most frequently occurring themes in responses to Question 1, asking about personal meanings of menopause, and Question 4, asking about aging, shows that expressions of distressing emotion was the only common theme. To further explore the differences, or similarities, in women’s construing of menopause and aging, an issue raised by Research Question 4, I undertook a statistical estimate of the relationship between the themes occurring in responses to Interview Question 1, and Interview Question 4. I again performed a Spearman’s Rank Order Correlation, with the result showing a weak correlation r(52) = .33, p < .05. Although women’s responses showed that they linked menopause with aging (as noted earlier 62% of women referred to an awareness of aging), it appears that women’s construing of menopause is distinct from their construing of getting older.

Responses to Question 5, “What is good about menopause?” showed that women predominantly construed the positive aspect of menopause as relief. They referred to relief from periods, and worries about pregnancy. A minor theme was relief from the costs associated with menstruation.

Responses to Question 8, which asked, “Are there any factors that you think affect/affected your experience of menopause?” again showed a strong percentage of distressing emotion. Not surprisingly, the question elicited references to key figures in women’s lives, mothers, doctors, and family, in addition to references to strategies and choices that women had made, such as taking hormone replacement therapy. Table 3,
in Section 5.6, showed the four most frequently occurring themes for each question asked in the interviews.

5.6.1.5 Summary of Responses to Research Questions

Research Question 1

Women’s meanings of menopause have been presented here in terms of the themes that were identified in their responses to interview questions. It is the full set of themes that represents most fully the meanings of the women, and provides a response for Research Question 1. The frequency of occurrence of themes is an indication of the relative importance of the themes in women’s meanings, with Symptoms, Expressions of distressing emotion, Expressions of difficulty in predicting what would happen, and Awareness of changes to the body, the most common themes, occurring in 70% and over of women’s responses. As noted in Section 5.6.1.1.(a), a major meaning of menopause for these women was the possibility, or actuality, of physical or psychological symptoms. The reference to symptoms by 87% of women suggests that the most fundamental meaning of menopause for most women is change, a reflection of the common name for menopause “The Change.”

Research Question 2

Responses for Research Question 2, asking how women construed other people’s constructions of menopause, were provided in Sections (f) References to mother’s experience, (r) Doctors, (s) Stigma and Taboos, and (t) Family. Sixty-two percent of women referred to their mother’s experience, and nearly half the women referred to doctors. It is clear that these were the key people that women consulted in trying to predict menopause. Women’s construing of the constructions of doctors however, was not always helpful, and sometimes led to invalidation, as described in Sections (f) and (r).
Forty-two percent of women referred, either directly or indirectly, to taboos or stigma associated with menopause. In a sense, this was a surprising finding given that, at the time of the interviews, there had been increasingly level of public debates about health issues associated with menopause. The answer appears to lie in the association of menopause with aging; women were self-censoring in revealing they were menopausal, as their construing of others’ constructions was that they would be perceived as old, and possibly “past it.” Section (t) describing the theme of Family, mainly reflected women’s anxious construing about the effect their menopausal experience had, or would have, on their partners or family.

**Research Question 3**

Responses for Research Question 3, asking whether women reconstrue, or maintain their self-construction, during and after the process of menopause, were provided in Sections (b) Expressions of distressing emotion, (d) Awareness of changes to the body, and (j) Acceptance. The frequent expressions of distressing emotion indicate that almost three-quarters of the women interviewed were experiencing a time of transition, with a need for change in their construct systems (Kelly, 1955/1991a). This, coupled with the fact that 70% of women spoke about changes to their body, suggests that the majority of women find that they need to engage in reconstruing themselves, at some level, at the time of menopause.

While 74% of women expressed indications of distressing emotion, 51% of women interviewed expressed some acceptance of menopausal changes, either in their predictions, or in their reports of menopausal or postmenopausal life. This apparent contradiction suggests that these women were engaged in a process of reconstruing.

**Research Question 4**

Responses for Research Question 4, asking whether women’s constructions about menopause differ from their constructions about aging, were provided in Section
(e). Sixty-two percent of women referred to aging in their responses, and the references were almost entirely negative, fearful, or expressions of difficulty in predicting aging. This was not the case for menopause as such. This was discussed more fully in Section 5.6.1.4, in relation to Interview Question 4, which asked about aging.

**Research Question 5**

Responses for Research Question 5, asking what choices women, particularly those in manager level positions, make to deal with menopausal change, were provided in Sections (a) Symptoms, (h) Strategies for dealing with menopause, (i) Hormone replacement therapy, and (n) Work. As noted in Section 5.2, the Sample was composed of 71.6% of women at “Professional” or “Manager” occupational level.

More than half of the women who had actually experienced menopause volunteered that they had experienced some difficulty at work, usually associated with hot flushes causing embarrassment. In personal construct terms, this may reflect guilt, as women experienced dislodgment from a core role, for example, that of professional, capable woman in control of herself.

Women reported the choices that they had made in dealing with menopausal symptoms. These included both physical and psychological approaches, such as lifestyle changes, alternative remedies, practical strategies for coping with difficulties such as memory loss, medical assistance, and spiritual systems. Some women’s choice was to reconstrue the symptoms of menopause to develop more positive meanings, such as reconstruing hot flushes as “power surges.” References to hormone replacement therapy were common. Fifty-five percent of women mentioned hormone therapy, often linked to expressions of anxiety. Suggestions for a menopause club, “grey Mardi Gras,” and menopause parties, reflected a loosening of construing about menopause, and a creative move to reconstruction and satisfying choices on the part of some women.
5.6.2 Menopausal Status and the Meanings of Menopause

In this study, women’s meanings of menopause did not vary significantly with menopausal status. There were, however, some differences in the frequency of themes between women of different menopausal status. In the following sections, examples will be used to illustrate the particular qualities of the quotations from women at different menopausal stages. A limited number of examples will be given for themes such as References to Symptoms, which have already been illustrated extensively in Section 5.6.1 above. In Table 7, which follows, the frequency of occurrence of themes in women’s responses is shown according to the women’s menopausal status, and also for the whole sample of women.
Table 7

*Frequency of Themes by Menopausal Status*¹

<table>
<thead>
<tr>
<th></th>
<th>Premenopausal</th>
<th>Perimenopausal or menopausal</th>
<th>Post-menopausal</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aware of symptoms</td>
<td>Aware of symptoms</td>
<td>Aware of symptoms</td>
<td>Aware of symptoms</td>
<td>Aware of symptoms</td>
</tr>
<tr>
<td>Distressing emotion</td>
<td>Distressing emotion</td>
<td>Unable to predict</td>
<td>Distressing emotion</td>
<td>Acceptance</td>
</tr>
<tr>
<td>Mother² Changes to body</td>
<td>Unable to predict</td>
<td>Changes to body</td>
<td>Unable to predict</td>
<td>Changes to body</td>
</tr>
<tr>
<td>Changes to periods</td>
<td>Strategies</td>
<td>Distressing emotion</td>
<td>Aware of Aging</td>
<td>Changes to Periods</td>
</tr>
<tr>
<td>Unable to predict</td>
<td>Doctors³</td>
<td>Medical/ health issues</td>
<td>Changes to Periods</td>
<td>Medical/ health issues</td>
</tr>
<tr>
<td>Strategies for coping</td>
<td>Changes: Aging</td>
<td>Marker/ Significant time</td>
<td>Aware of Aging</td>
<td>Changes to Periods</td>
</tr>
<tr>
<td>Aware of Aging</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relief</td>
<td>Changes to periods</td>
<td>Mother²</td>
<td>Strategies for coping</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Loss of role/control</td>
<td>Doctors³</td>
<td>HRT⁴</td>
<td></td>
</tr>
<tr>
<td></td>
<td>HRT⁴</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

¹ Note: themes are grouped together when they occur at a common frequency.
² Predictions based on mother’s experience
³ Awareness of change: visits to doctors
⁴ Exploring information about HRT

5.6.2.1 Women’s expectations of menopause

Premenopausal women who took part in this study (n = 30) had a predominantly negative view of the meaning of menopause.

(a) References to symptoms

The most frequent theme for premenopausal women was references to symptoms, to which 87% of the women referred. For example, Anita’s response was “my only association with it has been with work colleagues, who are either grumpy all the time, or have hot flushes or things like that, and that is basically my only
knowledge.” Kylie said: “It means the commencement of the period when you will no longer be able to have children and … all the symptoms that would go with it. In some cases I’ve heard it can lead to suicide.” Dora had seen her partner go through menopause and this had given her a worrying view.

   It means … probably experiencing more fatigue, more lassitude, less energy.

Perhaps an onset of a range of symptoms like hot flushes … An increase in appetite. Overwhelmingly I think the big thing, the biggest worry I have, is an overwhelming sense of fatigue as a consequence of it.

(b) Expressions of distressing emotion

The second most frequent theme was the expression of distressing emotion, which occurred in the responses of 70% of the women, who sometimes indicated quite disturbing feelings.

The words of Zoe were reported in greater detail in Section (e) in reference to aging, but it worth noting the bleak future that she envisaged. She said, “it is a bit intimidating to think of menopause. Because you will not be able to imagine yourself with, or as, an object of desire.” Fiona was disturbed during her interview, and reported great distress at noticing menopausal changes in herself, saying “it is like stepping outside that whole role of being a woman, and the menopause must mean the end of being a woman in some way.”

Geraldine expressed a common anxiety about hormone replacement therapy. I’m quite worried about it because of the impact … I think it probably does have impact on your body that you don’t necessarily hear … I find all that stuff about HRT so incredibly confusing and worrying.

Lisa’s response was not so intense, but nevertheless she said, “I am concerned about how it’s going to affect me.”
(c) References to mother’s experience

The third most common theme among premenopausal women was references to mother’s experience. It is consistent with a personal construct interpretation of menopause that women might draw on the experiences of their mothers, or other women’s mothers, in their efforts to anticipate menopausal changes. Some women, however, reported that their mothers did not, or would not, talk with them about menopause. For example, Fiona’s experience was: “I asked my mother about it and she wouldn’t tell me. She just said ‘oh it is just something that happens’.” Francis said: “I certainly didn’t discuss it with my mother and I’m on good terms with her.”

In contrast, there were mothers who had given their daughters a positive view of menopause. Hilda, however, found her anticipation of menopause, based on her mother’s positive experience, was not necessarily validated by other women:

I was talking about it … with a woman at work … I think she was slinging off that someone may be menopausal and that was … why they were so cranky, and I was saying “well I, in fact, don’t have a perception that it’s going to be like that, because my mother was perfectly okay.”

Women like Karen, whose mothers had had a difficult time at menopause, often expressed anxiety:

I think the only thing that I’m concerned about is … this incredible haemorrhage, and I know my mother had a similar experience happen, and she was out to lunch … which is most upsetting, the ladies luncheon. And so I have this horrible feeling that one day in a totally inappropriate and high level meeting … it will be me. I just can’t bear that thought.
5.6.2.2 Women’s Experience of Menopause

In this study, the three themes that occurred most frequently in perimenopausal and menopausal women’s responses were references to symptoms, distressing emotion and the inability to predict what would happen.

(a) References to symptoms

Extensive examples of women’s references to symptoms have already been given in Section 5.6.1 (a). The noticeable feature of menopausal women’s stories of their symptoms was that they reflected distressing emotion, and the anxiety of being unable to predict what was happening. At one level, unpredictability could affect these women in quite mundane ways. A number of women mentioned that an extra annoyance that attended erratic bleeding was that they could not wear the white clothes they normally might wear. For example, Yolande said “not knowing when your period was going to come, that was all a bit annoying, especially in summer with a white dress,” and Olive commented “And so it changed … in terms of, I don’t wear white clothes, the simple things ….” At another level, some women felt overwhelmed by the unpredictable symptoms and changes.

Olive had difficulty getting help for her symptoms, she found that her experience was not validated by medical evidence:

I could not stand the hot flushes … even though … the tests showed that my hormone levels were not low enough for them to put me on HRT. And then I got to a point where I was almost having panic attacks, and I was sort of thinking “maybe HRT will help.”

Harriet was uncertain about the meaning of her symptoms, “I also went through a stage of having lots of dizziness, and stuff like that, which is … one of the signs, and I am losing my memory, but I don’t know that that’s a sign really.”
(b) Expressions of distressing emotion

Many women saw menopause as a sign of changes they did not welcome, and they experienced distressing emotion. Therese thought that:

menopause has an unpleasant association … because it’s a little signal that you’re getting close to the end. … it is the last stage of life maybe. There isn’t anything else that is going to happen. Well … when you are a young girl and you get your periods, then you are … fertile. Then you get older, you don’t really think about it too much, it is just part of your life, and then this menopause hits, and then there is nothing else happens in the reproductive cycle, is there? It is like the last stage.

Winifred said, “I think a lot of women who’ve felt powerless all their lives, feel more powerless as they’re going through menopause, and more lost, and more mad.”

Harriet found that she was experiencing anxiety about changes in her appearance.

I don’t think I’ll care if nobody notices me, but you do. I do care. I care a great deal. I walk past a building site now and nobody looks … these days I find that quite depressing, and I think it’s probably odd … really is odd that I would think this. It’s just not something that you think about when people are looking at you in the street, and talking to you, and making way for you. As you get older people just crowd you out. I don’t like that at all.

The preceding quotation serves as a reminder of the individuality of personal meanings, which was, of course, demonstrated throughout the interviews. The sentiments expressed above form an antithesis to Rilda’s view about passing building sites, quoted earlier in Section 5.6.1 (j).
Expressions of difficulty in predicting what would happen

A key theme for menopausal women was the difficulty in predicting what was happening and what course of action to take. Women reported times when they felt their bodies were out of control. Therese’s experience illustrates this:

I had always had very regular periods for my whole life, and I suddenly started to have irregular ones … I found that really a bit distressing, the not having the regularity … a couple of times I was surprised, and I couldn’t plan things anymore, I was finding that quite difficult to deal with.

Pat compared her feelings about menopause to her feelings as a teenager:
It means an unknown, there’s so many vagaries about it, so difficult to find accurate information and it is really quite difficult to get some support. In a sense it is all those teenage things come back again about insecurity, confusion … I like to think I was a mature intelligent adult. …[and] that [I] cannot sort through some of these things, or that there is not more knowledge and support out there, is quite annoying.

Fran’s comment summarised the feeling of many women: “I’m very confused; I’m just fumbling along basically.”

The major theme of “difficulty in predicting,” subsumed a sub-theme of “discussion limited,” and this has been reflected in previous quotations. More than a third of perimenopausal and menopausal women, and indeed all the women in this study, mentioned the lack of opportunities for them to discuss, and gain understanding of their experience. The lack of discussion that women identified existed not only in medical and professional settings, it also extended to the family. Olive, for example, discussed the difficulty of experiencing menopause in a male-dominated household:

I am a female in a predominantly, well, an all male household, even the dog … I was trying to reflect on what does it mean to my family. And I think it means nothing
… my husband … would be aware of it, and he knows … some of the issues I have been talking about … but has never engaged in [it] as an issue for him. It is like something I am going through. And I have taken that as being just because I am surrounded by males. And I do not make a secret of it. I just often say “I’ve had enough” … but it is never talked about … The dog sometimes talks to me.

5.6.2.3 Women’s Recollections of Menopause

Post-menopausal women’s recollections of menopause ranged from a conviction that it had been an almost unnoticed part of their lives, to moving accounts of distressing experiences that still evoked a feeling of threat in recollection. The three themes that occurred most frequently in postmenopausal women’s responses were references to symptoms, the inability to predict what would happen, and hormone replacement therapy.

(a) References to symptoms

Prue gave a vivid description of the exhaustion that accompanied sleeplessness nights:

Being so tired that you walk around, and you become disconnected, it’s like you take a footstep, and you’re not quite sure how long that foot has been in the air before it touches the ground again. It’s like there are electrical moments that your brain switches off.

Stella’s memory of the distressing feelings that accompanied her menopausal symptoms continues to influence her choices:

I try not to put myself in a situation where I’m going to get really hot … I won’t choose a restaurant that I know I can’t get out of … it’s the same in planes. I’ve got to have air on me … I’ve associated the heat with getting panicky … I’ve worked out that … I felt more distressed when I had the hot flushes than at any other time … I was in a shopping centre one day … and I had one of these hot
flushes, and I was in a jumper, and I was almost ripping it off. I had to go into a ladies room … take it off. My daughter had to go and buy me a blouse because she could see I was getting all agitated.

(b) Expressions of difficulty in predicting what would happen

Iris remembered menopause as a very difficult time, when she had trouble predicting her own capacities:

In my mind it’s a memory, it’s a block of physical conditions. The headaches … with very heavy bleeding and almost a return to the beginning of menstruation which for me was really difficult as a 12 year old … It was going right back to the early days of adolescence. It didn’t seem fair … and an emotional side to it too … feeling that I was getting a bit daffy … forgetfulness and feeling that I was not really on top of things in terms of memory … work was such a huge part of life and these things affected work … being anxious about meetings or … would this … start to impinge on what I was doing? Would I ever know, would I ever be able to be prepared for not feeling at my best?

Sheila is a woman of 73, who had an extreme experience of menopause, clearly remembered, 30 years later, the threat and distress of not being able to predict what was happening:

I had a complete hysterectomy at 41 … and of course that meant the menopause … it was pretty horrendous … the doctor said to me … we’ve sent them [her ovaries] off for testing. My children were then aged four and five and a half, and I was lying in bed thinking, “well, if I can manage to last five years after this, they will be old enough.” And you know they didn’t come and tell me. When we got to five days after the operation, I said to one of the nurses “what happened about the tests.” “Oh” she said “Hasn’t anybody been to see you?”
and I said “no,” and she went off and got the doctor, and he said “oh that was all right, they were just cysts.” Oh! Oh! So they let me pass five days lying in bed biting my nails, and thinking what am I going to do, those poor children. It was pretty bad time … my GP gave me no advice whatsoever, didn’t suggest HRT or anything, just go home and get on with it. And I did go through a very bad time. I suppose it was depression in a way, but it was a pretty horrendous year or two after that.

Sheila recalled an acute lack of information for her generation:

I think the main factor that influenced me all through my life is ignorance. I knew absolutely nothing about the menopause, and my mother never talked to me about me anything. She didn’t tell me about menstruation, and one morning I woke up, and I thought I must be dying with all this blood, and she never told me anything about sex whatsoever. My first boyfriend told me. And she never discussed menopause. So all through my life I’ve been sort of surprised and shocked by all sorts of things.

Ursula is an older woman who remembered that her smooth menopausal transition was a surprise. Her lack of periods left her wondering what had happened, since there was no possibility of being pregnant:

I was forever hearing when I was a little girl about “she’s going through the change” or “she’s having a bad time” or “watch it she’s having a hot flush.” … I actually wondered for several months whether it was possible … if it isn’t, well bad luck, if I’m pregnant I’ve got a name I’m going to call it, ‘Jesus Christ’.

The women who experienced a distressing time at menopause, and whose predictions had been invalidated, were often left with a diminished sense of their choices. Prue said: “I used to feel that I had a power that I could keep on going, now I feel vulnerable.” Iris echoed this:
I thought beforehand I was pretty invincible; I was strong and fit, and competent and confident. The initial side of menopause rattled me a bit in that sense. This daffiness, and “am I really going to be able to be on the ball all the time” … realising you’re not physically as competent, and as at ease with your body, as you were before.

(c) Hormone replacement therapy

Women’s references to hormone replacement therapy were varied. For many women, their choices about the use of hormone therapy were integral to a discussion about menopause. For example, Beth commented: “I think the major factor is was whether to use or not to use HRT.” Some women had engaged in the circumspection phase of a decision-making process, but had not arrived at a choice. Lee said: “I’ve read a bit about hormone replacement therapy, and I appreciate that it is good for a lot of people, but there is this question mark about it maybe causing some breast cancer.”

Other women had worked through a decision-making cycle and were satisfied with their choice to use hormone replacement therapy as a means of alleviating their symptoms. Flora was satisfied with her decision: “I was getting very interrupted sleep, and that’s when I went on the HRT, solely to get a good nights sleep. And it worked.” Ruth, also, was satisfied with her choice: “there may be some minor physical elements of menopause that I think today is treatable and copable [sic] through hormone replacement therapy … I do not think it is the doom and gloom that our mothers painted.”

I have discussed the three most common themes for the women in terms of their menopausal status. It is important to note, however, that in contrast to premenopausal, perimenopausal and menopausal women, acceptance was a strong theme for postmenopausal women, and was the fourth most common theme for this group.
5.7 Post Interview Report

In the spirit of personal construct enquiry, after the data had been analysed for meanings, a report of the findings was sent to all participating women, with a request for comment. All respondents felt the findings reflected their meanings, and 54 of the 74 women from Study 1, volunteered to take part in the next stage of the research, Study 2.

5.8 Reflections on the Findings

The themes that I identified in women’s meanings of menopause, that represent the findings of this study, are, in general terms, supported by the findings of other studies. Woods and Mitchell (1999), reporting on the Seattle Midlife Women’s Health Study, found seven themes in women’s definitions of menopause: the end of periods, the end of reproduction, a time of hormonal changes, a change of life, a changing body, changing emotions, and an aging process. All of these themes were identified in this research. It is interesting, in view of women’s strong awareness of change in this study, that four of the seven categories directly refer to change, and the remaining three indirectly refer to change. The researchers made the point that the women “were most likely to be uncertain of their expectations of their own menopause” (p 167), again, a major theme in this research.

Lemaire (1995) found that women attending an educational program reported: that they had “a lot of questions without answers about menopause”; that “explanations they had received … were hazy to them”; that they were “undecided or unclear about the purpose of hormone replacement therapy”; that “healthcare providers did not use everyday language to help them understand”; and that they “were concerned about what the future might hold,” as “it was not clear what was going to happen to them” (p 43). These themes of difficulty in predicting what would happen, references to hormone
replacement therapy, and references to difficulties with healthcare providers, are also themes that were identified in this research.

The theme of acceptance and reconstruction, and a contrasting theme of loss of role or loss of control, found in this research, has also been found in other studies. Picard (2000) found themes of “relationships with others, self, and spirit as well as challenges of loss, illness, and threats to relationships” (p 150). These polarities are also reflected in other research. In terms of acceptance and reconstruction, Malone (1998) claimed that turning 50 is an emotional rite of passage for most women. She said “the most exciting change has been discovering that I have within my soul the power to tell myself stories and to seek out stories that other women have told of growing old” (p 71). McQuaide (1998b) cited Apter 1995, who found that “a woman’s most important insight was that she could at last listen to her own voice” (p 23). In a review of menopause research Degges-White (2001) drew the conclusion that: “generativity in midlife women is a strong force” (p 10), referring to women’s realisation of feelings of freedom and empowerment. A survey conducted by the North American Menopause Society found that 51% of the postmenopausal women surveyed “reported being happiest and most fulfilled between the ages of 50 to 65 years” (p 122), and Gersick and Kram (2002) found that high-achieving women had a sense of coming into their own at the age of 50 and beyond. Gannon and Ekstrom (1993) found that women’s attitudes about menopause became increasingly positive with age and/or experience.

On the other hand, McQuaide (1998a), who reported on a study of white women living in the suburbs of New York, found that a quarter of the women reported a significant lack of contentment and satisfaction midlife. These women identified a number of areas of concern, including physical vulnerability, marital dissatisfaction, anxiety about identity, a lack of self-acceptance, and unresolved grief, anger, and loss.
This group of women, who were concerned about physical vulnerability, may represent a group identified in a large-scale study in America: Sowers et al (2001) found that: “even at the relatively early age of 40 to 55, approximately 20% of women self-reported limitation in physical functioning” (p 1485). It is likely that, in this study, the concerns of women such as these are represented by themes such as references to symptoms, expressions of distressing emotions, and awareness of changes to the body.

The theme of stigma and taboos, found in this research, was also found in a study involving participants in a national Midlife Women’s Health Study in the United States (Kittell et al., 1998). Researchers found two key concepts occurring in women’s accounts of menopause, concealment and control, with a “core variable of keeping up appearances” (Kittell et al., 1998, p 621). This behaviour of concealment was linked to the concealment of menstrual bleeding that, as the authors say, “was not new to women” (p 621).

5.8.1 Limitations of Study 1

The choice of sampling methodology was based on a research strategy grounded in an ethical framework relating to women occupied outside the home. While appropriate for this study, it limits the ability to generalise from the findings. The outcomes are therefore applicable only to other women with comparable characteristics to those interviewed.

A further limitation to the interpretation of the data was the lack of suitable definitions for menopausal status. Future studies should provide women with formal definitions of menopausal status before asking them to nominate their own status. This should reduce the confusion on this issue, and would allow a more accurate reading of the data in relation to different patterns of construing that might occur at different menopausal stages. I comment further on the limitations of this research in Chapter 10.
5.8.2 Conclusion

A number of writers have commented on the predominantly negative images of menopause portrayed in the media and the menopausal literature (McQuaide, 1998b; Robinson, & Stirtzinger, 1997; Rohrbaugh, 1981), and the potential “influence on women of social and scientific discourses in circulation” (Seibold, 2000, p 147). Overwhelmingly, the meanings of menopause were negative for the women in this research. Their lived experience was negative, regardless of the role that external accounts might play. The themes of awareness of change, particularly in the body, expressions of distressing emotion, and expressions of an inability to predict what was happening, were constant, regardless of women’s menopausal status. Women spoke of a lack of opportunities for discussion, and their difficulty in decision-making in this context.

In this Chapter I have reported on the findings of Study 1. I have looked at the data through different prisms. Firstly, I presented the themes that were identified in women’s interview responses, in order of their frequency of occurrence, revealing the most frequent meanings of menopause for this group of women. Secondly, I looked at the themes in relation to the Interview Questions, and reported the results of statistical investigations into relationships between responses to Interview Questions. Thirdly, I discussed the themes and meanings in relation to the light they shed on the Research Questions. I then analysed the data by menopausal status, to provide a picture of the differences between the meanings of women at different phases of the menopausal transition.

In the next chapter, I present an evaluation of interventions for menopausal women and women in midlife. Firstly, I evaluate psychologically based groups and workshops, and then educational groups and workshops. Finally, I comment on the
limitations of group interventions for menopausal women that have been reported in the menopausal literature.
CHAPTER 6

MENOPAUSE AND INTERVENTION: A REVIEW OF GROUP INTERVENTIONS FOR WOMEN EXPERIENCING MENOPAUSE
In this Chapter, I review group interventions, and their evaluations, for women experiencing menopause. I begin by discussing the need for psychologically-based group interventions for these women. I then provide an account of the available groupwork for menopausal women reported in the medical and psychological literature. First, I describe psychologically-based groupwork for menopausal women, and evaluate this research. Next I describe educational groupwork, and evaluate the research. Finally, I discuss the limitations of the outcome research for psychologically-based and educational group interventions in the literature.

6.1 The Need for Psychologically-Based Interventions for Menopausal Women

Despite a strong emphasis on symptoms, depression, and distress, in the menopausal literature (Bosworth et al., 2001; Boulet et al., 1994; Bromberger et al., 2001; Coope, 1996; Kaufert et al., 1992; Kurpius et al., 2001; Pariser, 1993; Stewart, Boydell, Derzko, & Marshall, 1992), and an acknowledgment that menopause occurs “at a strategic time in life” (Speroff, 1996, p 64), psychologically-based interventions for menopausal women are rarely reported. The menopausal interventions reported are predominantly medical, with hormone replacement as the most frequently cited therapy, followed by complementary therapies (Seifert, Galid, & Kubista, 1999; Sherwin, 1994; Sirtori, 2001; Sismondi et al., 1999). The non-medication based interventions reported are most often education programs (Blalock et al., 2002; Lemaire & Lenz, 1995; Liao & Hunter, 1998).

It is clear, however, that some sections of the medical professions are aware of the need to address women’s worries about menopause (Graziottin, 1999). The North American Menopause Society, (North American Menopause Society, 2000a) in a consensus opinion, called for women to be included in the “management decision-making process” (p 6) in relation to their treatment, a statement reflecting an absence
of consultation that women might surely have expected. The Society also published an investigation of women’s access to hormone replacement therapy counselling from healthcare providers (Ettinger, Woods, Barrett-Connor, & Pressman, 2000). The counselling referred to in this research was provided by medical practitioners in relation to hormone replacement therapy. The researchers concluded that, while three quarters of the sample of 749 women had received counselling about hormone replacement therapy, women of the lowest socioeconomic status, and those who did not have a primary care physician were the least likely to have received this.

The North American Menopause Society (NAMS) has compiled two databases to assist “the hundreds of consumers who contact NAMS for help each month” (Boggs & Rosenthal, 2000, p 207). These consist of the referral list of menopause clinicians, and a list of menopause discussion groups. Boggs (2000) reported a lack of discussion groups for women “who wanted to share how menopause affects them and to learn about menopause to help them make more informed health decisions” (p 207). She also reported that, although many communities offered lectures to large groups of women, very few offered small discussion groups. The NAMS therefore published a guide to assist health care professionals in developing menopause discussion groups of approximately eight women in their communities (Boggs & Rosenthal, 2000).

In the nursing literature, there are references to the need for interventions to assist women to make decisions related to menopause (O'Connor et al., 1998), for nurses “to come to terms with the continuing conflict related to hormone therapies” (Herrick, Douglas, & Carlson, 2002, p 153), and to normalise the menopausal transition for women from diverse cultural backgrounds (Im & Meleis, 2000). Self-help groups have also been recommended (Goldstein, 2000). Large teaching hospitals, and women’s health centres, often run education programs or support groups for women approaching menopause. Although these services often receive positive
feedback from their service-users, there is relatively little published evidence of the nature and effectiveness of education programs and support groups. In a related area, a leading researcher in the menopause field claimed that “traditional ‘menopause clinics’ have been dismally unsuccessful in initiating broad programs of preventive medicine” (Utian, 1997, p 81), that is, they had failed to engage a large enough number of women to make an impact on the health of older women. Caltabiano (1999) recommended: “psychologists, and professionals working in menopause clinics may need to promote feelings of optimism and a sense of coherence in menopausal women” (p 21).

6.2 Psychologically-Based Groups and Workshops

Only a small number of psychologically-based exploratory studies and group interventions for menopausal women have been reported. There is, however, some recognition of the need for psychological services. Huffman and Myers (1999), designed a seven phase guide for counsellors when working with menopausal women. This initiative was in response to what they saw as the confusion and fear that make menopause a troubling time for some women, and their recognition of women’s need to make sense of their experience. The authors argued that menopause is a normative life transition, which requires counsellors to use an integrated approach taking account of biomedical, cultural, and psychosocial factors. The guide includes education, biomedical issues, self-assessment, dialogue, and definition, creating a plan, implementing the plan, and re-evaluation. There was no report, however, that the guide had been tested, and no evaluation was proposed.

Other researchers have reported on the challenges to women’s well-being at the time of menopause, and the need for psychologically-based interventions. Researchers involved in a European preventive medicine program, involving over 5,000 women concluded: “problems involving mental well-being seem to affect a significant number of women” (Concin et al., 2002). Reynolds (1997b) conducted a study of 56 women,
which explored the women’s descriptions and concerns during hot flushes. The researchers reported that lack of information, and effective medical support, was a common problem experienced by the women. Women’s feelings of distress in relation to hot flushes were also reported as an issue that should be addressed in counselling (Reynolds, 1997a).

Some menopause clinics have attempted to provide a service that integrates psychological care with other health care services (Hamburger, 1990). For example, the University of California, San Diego, Menopause Clinic developed a “multidisciplinary approach to the problems and experiences of women in menopause” (Hamburger, 1990, p 315), using medical, social and psychological counselling, and educational techniques. Similarly, the Mid-Link Menopause Service in Western Sydney, New South Wales, Australia, offers a clinic, counselling, and support groups, and has published a literature review of cross-cultural research on menopause (Mid-Link Menopause Service, 1999).

6.2.1 Findings from Psychologically-Based Groups and Workshops

Although there is an extensive menopausal literature, which contains a number of specialist journals, I have found only four studies that attempt to evaluate a psychologically based intervention. This result is not surprising in the light of the finding of a German study (von Sydow & Reimer, 1995), which found, in a study of the German and English language menopausal literature, that only 10% of those studies even considered psychological aspects of menopause.

Anarte et al (1998) reported a study of 73 “climacteric women” in Spain. Women were randomly assigned to either a hormone replacement therapy group, or to a hormone replacement therapy plus psychological treatment group. Groups of seven or eight women took part in 10-16 sessions of 30 minutes duration, over a period of six months. The psychological treatment had three components: educational, counselling,
and behavioural. The educational component consisted of information about “the role played by psychosocial factors in their condition” (p 206), and the advantages and disadvantages of hormone replacement therapy. The counselling component consisted of discussion and advice about the women’s “current problems and concerns” (p 206). The researchers commented that this component was “not a psychotherapeutic procedure as such, but … a problem-solving exercise” (p 206). The behavioural component was cognitive therapy for depression, and strategies for coping with stress. Psychological symptoms were assessed using items from a number of self-report questionnaires and scales, such as the Beck Depression Index. The study used a pre-and post-intervention test design. The researchers found that hormone replacement therapy in conjunction with psychological support was more effective than hormone replacement therapy for a range of psychological complaints such as nervousness, melancholy, and fatigue. Interestingly, hormone replacement therapy alone was more effective for vasomotor symptoms, for example, hot flushes, even though it appears both groups of women received the same hormone regime, although the researchers do not comment on this result.

Anderson et al (Anderson, Hamburger, Liu, & Rebar, 1987) established a program for women attending a menopause clinic. It consisted of group discussions with four to six women, followed by a personal counselling session with each patient. The group session, conducted by a health professional, provided information, and patients were encouraged to discuss their problems, fears, and frustrations. In the individual counselling session, patients could see a doctor, psychiatrist, career counsellor, or nutritionist. Anderson reported that follow-up questionnaires were mailed to the first 100 participants and their partners six months after attendance. Results included reports of improvements for the women, for example, that 80% of the patients believed that their visit had been useful.
In Japan, counselling was found to be an effective intervention for treating both physical and psychological symptoms (Takamatsu, Ohta, Makita, Horiguchi, & Nozawa, 2001). Takamatsu et al evaluated the effects of counselling on menopausal symptoms in Japanese women. They studied 44 women, using a Japanese menopause index to assess symptoms. The researchers commented that “physical symptoms accounted for most of the common symptoms” (p 133) shown by the women. Over 90% of the women showed an improvement in the index score after counselling, the most improved symptom being headache, followed by palpitation and insomnia. The researchers concluded that counselling may deserve evaluation as a complementary treatment, particularly as it was found to improve physical symptoms.

A British study (Jones, Keene, & Greene, 1999) described a four-session Middle Years Group devised by staff from a general medical practice. This group included a psychologically-based component, and was led by a health visitor and a counsellor. One hundred and sixty-three women attended the groups, 12% of those invited. The sessions were 90 minutes each, with 12-16 women in each group. The aim of the intervention was to assess the effect of the group sessions on use of hormone replacement therapy, anti-depressants, and use of counselling services. The women’s views on the group were assessed by a questionnaire, which was not described. The women’s use of hormone replacement therapy and anti-depressants were obtained from patient records, and compared to the records of a matched group of women, who were invited, but did not attend the group. The intervention consisted of Session 1, which was an introductory session; Session 2, which dealt with physical health issues, and was led by the health visitor; Session 3, which focussed on coping with change, and was led by the counsellor, who encouraged the group to share any emotional problems they had experienced in relation to the effects of change; and Session 4, which consisted of a talk about hormone replacement therapy by a doctor.
No significant differences were found between the intervention and contrast groups in terms of drug use, or use of counselling services. The researchers reported that the group was well received by the patients, and that the staff involved had found the experience worthwhile.

It is possible that other psychologically based studies are being conducted, or have not yet been published in this area. For example, The National Institute of Mental Health in the United States Clinical Trials website (National Institute of Mental Health, 2003) shows that a trial is currently being recruited for a study of interpersonal psychotherapy as a treatment for depression associated with menopause.

6.2.2 Evaluation of Psychologically-Based Groups and Workshops

Psychologically-based groups and workshops for menopausal women often show some benefit having been provided for the women. They are, in general, disappointing in design. While some studies use randomised sampling techniques, a well-designed therapy outcome study should include four aspects: provision of baseline data for contrast with postintervention data; the use of one or more contrast samples; collection of comparison data after a period has elapsed postintervention; and reporting of retention rates (Viney, 1988). In addition, from a personal construct perspective, it is desirable to collect data that reflects individual meanings and provides insight into implications of the data for the participants. Furthermore, the inclusion of a method of eliciting participants’ comments on the results would add to the validity of the evaluation strategy. Many studies omit either the use of contrast samples, or the collection of follow-up data, and most omit the inclusion of the participants’ comments on the findings.

Anarte et al (1998) conducted a substantial six-month intervention with 73 women. Given the resources committed to that, it is unfortunate that no follow-up testing was reported assessing the longer-term outcomes of the study. Although the
study used random assignment to samples, and a pre- and post-intervention test design, evaluation depended on solely on self-report questionnaires and scales, completed after the intervention. This study would have been strengthened by the use of a more varied, longer term evaluation strategy.

Anderson et al (1987) established a program of group discussions, followed by a personal counselling, for women attending a menopause clinic. The use of a single evaluation strategy, a self-report questionnaire, limits the conclusions that can be drawn from this study: no comparable baseline information was described, no further follow-up was undertaken, and no comparison group was included in the study.

Takamatsu et al (Takamatsu et al., 2001) found counselling to be an effective intervention for treating both physical and psychological symptoms. Unfortunately, no comparison group was used, and no follow-up data or details of the counselling were reported.

Jones, Keene, and Greene (1999) ran a four-session group for women attending a general medical practice in Britain. They evaluated the group using a questionnaire. The researchers reported that the group was well received by the patients, and that the staff involved had found the experience worthwhile. The actual results of the questionnaire, however, were not reported. The lack of more comprehensive design and evaluation strategies prevents the formation of further conclusions.

6.3 Educational Groups and Workshops

Educational groups for menopausal women have been more frequently reported than psychologically-based interventions. Some researchers, however, acknowledge the psychological impact of the context in which women experience menopause: “if belief systems, misinformation, attitudes, and concurrent worries can influence the experience of menopause, then, by altering an individual’s myths or negative expectations and/or helping her deal with her concerns about menopause, it should be
possible to reduce both psychological and physiological distress during this transitional period” (Robinson & Stirtzinger, 1997, pp 165-166). Robinson and Stirtzinger (1997) cite research showing that, for women, the worst thing about menopause was not knowing what to expect and that 80% of women would like more information about menopause before its onset.

### 6.3.1 Findings from Educational Groups and Workshops

Stirtzinger et al (cited in Robinson & Stirtzinger, 1997) reported a study of educational workshops, which consisted of three three-hour sessions covering the physical, psychological, and psychosocial issues related to menopause and women at midlife. Each workshop had 20-30 participants, with a mixture of pre-, peri-, and postmenopausal women. The goals of the workshops were to dispel myths about menopause, provide up-to-date, information, and “increase women’s sense of mastery with regard to their health and lifestage changes” (p 167). The workshops were conducted by an gynaecologist or family practitioner and a psychiatrist. Although the primary objective of the workshops was to provide women with information, “network building and discussion among participants were important” (p 168). The workshop included discussion of focus questions, some of which were proposed by the women, and the women discussed the ways in which they felt that they could gain control over the experience of menopause.

The researchers used questionnaires before and after the program to assess its effectiveness. The details of the questionnaires were not reported. The findings were that women felt significantly less anxious, less depressed, less irritable, and generally more hopeful about themselves after the workshop” (p 168). Women who completed follow-up questionnaires one year after the workshop, also indicated that they continued to benefit from the program. The researchers concluded that: “the
menopausal educational workshop was effective in reducing stress and helping the participants feel more hopeful about their lives” (p 169).

Garcia Sanchez et al (1998) reported on a “semi-experimental study with a comparison group” (p 215). The study consisted of an evaluation of an educational program, which consisted of exercises, relaxation, and group discussions. Groups of 8-10 women took part in 10 weekly, hour-long sessions, administered by four female nurses. The researchers used a health questionnaire, before and after the intervention, to evaluate any effects. The findings were that there was a statistically highly significant difference between the intervention and comparison groups after the intervention in relation to mental disorder. No follow-up data were reported, however, and effectiveness was assessed using only a questionnaire.

A number of studies have acknowledged that decision-making about hormone replacement therapy is a concern for menopausal women. Marmoreo et al (1998) conducted an exploratory study of menopausal women’s decision-making processes, using eight focus groups. The researchers concluded that internal influences, benefits of HRT, negative side effects, and interpersonal relationships, were the factors that were most important in women’s decision-making. Murray et al (2001) developed a decision-making aid to provide women with a means of playing a more active part in decision-making about hormone replacement therapy. While the findings in the short-term, after three months, were encouraging, after nine months some differences between the contrast group and the decision-aid groups had disappeared. A reduction in “decisional conflict” was however more pronounced for the treatment group.

O'Connor (1998) developed and tested a decision aid, consisting of an audiotape and booklet, for women considering hormone therapy after menopause. The audiotape guided women through the booklet, which contained information about benefits and risks of hormone replacement therapy, and a values clarification exercise.
The researchers observed that the decision aid differed from other education materials, because of the focus on alternatives, and the inclusion of values clarification, to assist women in making decisions based on their own individual needs. The aid was tested with 94 women recruited from family practices in Ottawa, Canada. Participants completed a recruitment screening questionnaire, and a baseline questionnaire eliciting the women’s knowledge and expectations of hormone replacement therapy, which consisted of statements to be marked as true/false/unsure. The women then used the decision aid, from which decisional conflict scores were generated, and completed a post-decision aid questionnaire asking about their reactions to the intervention.

The findings were that there was a significant decline in total decisional conflict scores, and a significant increase in knowledge, realistic expectations, and clarification of values. Although the aid had little impact on the women’s actual decisions, the researchers reported that the women were more comfortable with the process they used to make their choice.

Rostom, O’Connor and Wells (2002) conducted and evaluated a randomised trial to determine whether a computerised or an audio-booklet decision-aid, for women considering post-menopausal hormone replacement therapy, was the more effective. They used pre- and postintervention questionnaires to assess the women’s perceptions and knowledge of the risks of hormone replacement therapy use, and satisfaction with the aid. The findings were that the computerised aid was the more effective aid. Women’s realistic expectations increased 52.7% following their use of the computerised aid, and by 27.6% after their use of the audio-booklet. The women’s knowledge scores improved by 17.5% after using the computerised aid, and by 8.4% after using the audio-booklet aid.

Lemaire and Lenz (1995) assessed an educational program on menopause, using a measure of uncertainty (Mischel Uncertainty in Illness Scale-Community Form
MUIS-C), and a short true-false test developed by the researchers, using a one group pretest, post-test design. The intervention consisted of information provided in a lecture, followed by a question and answer session. Before the intervention, the women reported that they had “a lot of questions without answers about menopause,” that “explanations they had received … were hazy to them,” that they were “undecided or unclear about the purpose of hormone replacement therapy,” that “healthcare providers did not use everyday language to help them understand,” and that they “were concerned about what the future might hold,” as “it was not clear what was going to happen to them” (Lemaire & Lenz, 1995, p. 43). The researchers found that the women’s levels of uncertainty about menopause decreased significantly after the program, and concluded that uncertainty was an important phenomenon associated with menopause. From a personal construct point of view, it is interesting that the researchers speculated that new information might stimulate “reconceptualisation of the context in which symptoms and events are interpreted” (p. 47). This could be interpreted as recognition of some of the processes involved in the C-P-C Cycle decision-making cycle.

In relation to women who attend menopause programs, Fox-Young (1999) assessed knowledge about menopause of two groups of women: a random sample, and 95 women who attended menopause seminars. The researchers found no differences between groups on commonly available knowledge or biomedical knowledge, and concluded that the finding “challenges the widely held assumption that active information-seekers are more interested and have a better level of knowledge than the general population” (p. 37). This finding, however, does not provide any information about the relative levels of anxiety or distress of women who take part in menopause programs.
Liao and Hunter (1998) evaluated the short-term outcome of a health education intervention with 86 women in London. The intervention consisted of two education sessions carried out in small groups. Women were randomly allocated to either the intervention or control condition. Evaluation of the intervention consisted of questionnaires completed pre- and postintervention, three and 15 months later, to assess knowledge and beliefs about menopause, and to assess other health-related behaviours such as incidence of smoking and prevalence of regular exercise. The findings were that knowledge improved significantly for the intervention group, and that the women’s beliefs about menopause became less negative, both in the intervention and the control group. The negative beliefs were scored on items such as decline of physical attractiveness, ageing and death. The researchers found no significant change in incidence of smoking, or prevalence of regular exercise, although there were some improvements. The researchers noted the “modest benefits” (p 224) of the intervention, but suggested that “interventions carried out before menopause might meet women’s desire for information and encourage more accurate expectations about menopause” (p 224).

Other educational programs yield positive results, and describe processes, but do not include evaluations of effectiveness. McQuaide (1996) described an educational group with 12 women in midlife. The purpose of the group was to provide support and education. It met weekly for two hourly sessions, for six weeks. McQuaide reported on examples of processes in the groups, and the use of exercises such as “sculpting midlife,” an activity where a volunteer used group members to represent and sculpt her relationships. The examples quoted throughout the report indicate that the women enjoyed, and may have benefited from, the group. McQuaide did not, however, use any measure to evaluate any changes that may have occurred for women after taking part in the group.
Weiss (cited in Robinson & Stirtzinger, 1997) conducted a series of educational/support programs for menopausal women, which ran for 8 consecutive weeks in the lunch hour. The program was sponsored by the Employee Wellness Program at the Mount Sinai Medical Center in New York City. Teams of interdisciplinary health care professionals provided information on topics ranging from exercise to sexuality. The organizers then modified the program for a community based in East Harlem. It consisted of a nine-session program lasting four months, held in a community centre. Again the emphasis was on education, but in this case a respected member of the community acted as a liaison between the women and the local hospital. Child-care and refreshments were provided, and the program was adapted to the needs of the local women. Weiss reported that the program “worked” because of these modifying factors, however it is not clear how effectiveness was evaluated.

Mingo et al (2000) conducted 23 focus groups with non-Hispanic white, Hispanic, and Navajo women in New Mexico, to investigate possible ethnic variations in women’s attitudes towards and experience of menopause and related events. The study found that traditional Latina and Navajo women “related few to no menopausal symptoms” (p 27). All the women reportedly “participated freely in the storytelling focus groups” and may have benefited from this, but as the study was exploratory, there was no evaluation of the effects of participation in the groups. Ciornai (1999) reported research with Brazilian women who took part in interviews and workshops. The researcher reported that the workshops served a therapeutic purpose as awareness-raising groups for the women, and that such workshops would be a way of supporting women during the menopausal phase of their lives.

There are other initiatives for menopausal women that have been reported in the literature, but not evaluated. For example, I have not found any evidence of
systematic evaluation of groups such as the internet support groups reported in Chapter 2, in Section 2.3.1, or the discussion groups that organisations such as the North American Menopause Society are promoting. The continued existence of groups, such as the internet groups however, are evidence that they fill a need for some women.

### 6.3.2 Evaluation of Educational Groups and Workshops

Stirtzinger et al (cited in Robinson & Stirtzinger, 1997) conducted educational workshops for menopausal women. The results of this intervention were encouraging, took account of some psychological factors, and the women were able to play an active role in some parts of the program. No contrast group was included in the study, however, and the researchers only used self-report questionnaires to evaluate the effectiveness of the workshop. The exclusive use of self-report measures is problematic. They provide an important, yet limited, and “potentially biased report of therapy outcome” (Ogles, Lambert, & Masters, 1996, p 5). It appears that the women felt better after the educational intervention, even after one year, however in the absence of a more rigorous design it is difficult to assess accurately either the degree of improvement, or the effects of bias.

Garcia Sanchez et al (1998) reported on a semi-experimental study with a comparison group. No follow-up data were reported, however, and again, effectiveness was assessed using only a questionnaire.

O'Connor (1998) developed and tested a decision aid, consisting of an audiotape and booklet. The authors acknowledged some limitations to the study, which included the lack of a contrast group, and the hypothetical nature of the decision-making. They also noted that the effect of the changes on outcomes such as fear, regret, and the persistence of the decision-making, was unknown, and that the study did not include a follow-up. These researchers reported that they were planning to address these issues in further research.
Rostom, O’Connor and Wells (2002) conducted and evaluated a randomised trial to determine whether a computerised or an audio-booklet decision-aid was more effective for menopausal women’s decision-making. They used pre- and postintervention questionnaires to assess the women’s perceptions and knowledge of the risks of hormone replacement therapy use, and satisfaction with the aid. Again, the researchers only used self-report questionnaires to evaluate the program, providing a limited source of information.

Lemaire and Lenz (1995) assessed an educational program on menopause, using a measure of uncertainty (Mischel Uncertainty in Illness Scale-Community Form MUIS-C), and a short true-false test developed by the researchers, using a one group pretest, post-test, design. There were a number of limitations to the study that were acknowledged by the researchers. The women were recruited from a group who had paid to attend an educational program, and were likely to have had a high interest in, and uncertainty about, menopause. No contrast group was used, and there was no longer-term follow-up, although the researchers recommended that the duration of the effects should be ascertained through further study. Evaluation of the intervention was based solely on self-report questionnaires.

Liao and Hunter (1998) evaluated the short-term outcome of a health education intervention with 86 women in London. The intervention consisted of two education sessions carried out in small groups. No contrast group was used, and the evaluation strategy relied solely on questionnaires. The study would have been strengthened by the use of additional, more sensitive, measures assessing individual meanings, which might have clarified the similarities, or differences, between the meanings of the women in the groups, and shed light on the persistence of some unwanted behaviours.

In the educational groups and workshops that contained an evaluation strategy, in each case it consisted solely of questionnaires. In some cases, a pre- and
postintervention design was used, but in others the evaluation consisted only of postintervention questionnaires, a very inadequate measure of effectiveness.

6.4 Limitations of Group Interventions for Women in Midlife

Despite the relative lack of published evidence, it is clear from the literature that clinicians believe that women benefit from group interventions for menopausal women. McQuaide (1998a) recommends midlife therapy groups for women who experience a lack of satisfaction in life at that time. She comments that “a positive sense of self can blossom best in the context of validating relationships with others” (p 560), and that therapy can be used to help clients build connections and avoid isolation. She adds: “groups are safe places to practice the use of newly reclaimed parts of the self and to get honest feedback with which to build identity” (p 560). In addition to the individual benefits that they may provide, group programs have financial benefits that are important for service providers. Robinson and Stirtzinger (1997) conclude: “group programs for menopausal women are cost-effective ways to help those women who experience physical and emotional distress around this midlife change” (178).

Robinson and Stirtzinger (1997) also draw useful conclusions about women’s participation in psycho-educational programs. They draw attention to the social restraints that women might experience. They comment on the importance of taking services into a setting that women find comfortable and accessible. To attract a wide range of women, programs should be offered in a range of settings to avoid those, such as a clinic, that might indicate an “unwanted label such as psychiatric patient or one associated with poverty (such as social agencies) or radicalism (such as the feminist health collective)” [brackets in original] (p 172).

Although some useful observations can be made from studies that do not include evaluation, questions remain about their usefulness. Hogan et al (2002) investigated 100 studies of support interventions, in which problems ranged from
cancer to loneliness. They found two studies that reported women being
disadvantaged by a support intervention, and pointed out the importance of careful
evaluation of support interventions, prior to widespread implementation. They
commented on the “surprisingly little hard evidence about how, and how well, social
support interventions work” (p 381), and concluded that it was still unclear whether
support interventions are consistently effective modes of treatment, and also that it
might be useful to match patients to treatment. Greene (2002) raised a concern in the
menopausal literature about psychosocial research into menopause, and concluded that
if more clinically derived considerations were taken into account in the methodology
and design of such studies, that they would provide a more clinically relevant evidence
base.

Despite research drawing attention to the need for psychologically based
interventions, few initiatives have been reported. In terms of Viney’s (1998) criteria
for a well-designed therapy outcome study, noted at the beginning of Section 6.1, I
found no study that met all of the criteria. The lack of contrast samples, the omission
of baseline, and follow-up, comparison data, and limited evaluation strategies, were
issues of concern.

A small number of studies randomly assigned women to treatment groups,
many other studies did not report their recruitment processes. Despite the fact that
randomisation of subjects represents the acknowledged standard for scientific research
(Moher, Schulz, Altman, for the CONSORT Group, 2001a), the ethical issues arising
from this are problematic in some areas, including psychological practice. The
decision to exclude patients from a potentially helpful treatment, on the basis of a
random distribution, is ethically debatable (Miettinen, Yankelevitz, & Henschke,
2003). A more ethical approach would be to screen women prior to an intervention, to
predict those women who should benefit most, with the remaining women forming a contrast group. No study reported such a screening process.

Any evaluation strategy that is not multidimensional (Ogles et al., 1996), and that fails to report methods for ensuring the integrity, validity, reliability, and accuracy of the findings (Patton, 1990) is subject to challenges to its credibility.

In the next chapter, I shall discuss personal construct approaches to therapy and workshops, with a particular focus on group therapy. I also present details of a brief intervention, based on a personal construct approach: a Menopause Workshop for women experiencing or anticipating menopause.
CHAPTER 7

PERSONAL CONSTRUCT APPROACHES TO
THERAPY AND GROUPWORK
In this Chapter I begin by discussing personal construct approaches to therapy, which I briefly outlined in Chapter 3. I summarise some key concepts, such as constructive alternativism, reconstruction, a mutual orientation approach to experimentation, and a credulous approach. I then consider personal construct approaches to therapeutic movement, and discuss strategies for movement described by Kelly (1955/1991b), and other personal construct clinicians. Next I consider personal construct approaches to group work. Within that section, I discuss group processes, strategies and factors helpful for groupwork, and criteria for evaluating change. Finally I introduce, and describe, the Menopause Workshop, designed for women in midlife.

7.1 The Theoretical Background for Personal Construct Therapy and Groupwork

In Chapter 3, I discussed the personal construct approach to the potential for change, and the centrality of change in personal construct theory. This orientation towards change is crucial in creating a hopeful basis for personal construct approaches to therapy and groupwork.

7.1.1 Constructive Alternativism and the Individual

A personal construct approach to therapy is grounded in the assumption of constructive alternativism, which I considered in Chapter 3. This assumption is ultimately an expression of the possibility of change in a person’s construct system. It implies that meanings are functionally constructed (Raskin, 2001), that “creators of constructs can change them” (Viney, 1996, p 78), and that freedom “comes with our ability to construe our circumstances and then reconstrue them” (Dalton, 1993, p 99). The person is central to personal construct therapy, as Epting (1984) observed, and an emphasis on the person is, above all, an emphasis on the primacy of the person’s own meanings and experience.
7.1.2 Reconstruction

Kelly’s (1955/1991b) view was that the focus of therapy was “the problem of reconstruing life” (p 830). His theory was designed “primarily with the area of clinical psychology as its focus of convenience” (p 319), and the stated goal for his “theory-building efforts” was “finding better ways to help a person reconstrue his life so that he need not be the victim of his past” (p 23).

Reconstruction, is therefore, the essential aim of a personal construct intervention (Fransella & Dalton, 1990), but importantly, it should enhance useful predictions (Viney, 1996), and provide the basis for more flexible and creative construing in the future (Harter, 1988). Kelly (1955/1991a) believed that “the task of psychotherapy is to get the human process going again so that life may go on and on from where psychotherapy left off” (p 223). Epting and Prichard (1993) have observed that “personal construct psychotherapy is ultimately an enterprise aimed at psychological movement” (p 37), and therefore “the client’s experience of the process must involve novelty” (p 37), through discovery and invention. Personal construct approaches to therapy reflect a focus on individual meanings and an experimental attitude. As Neimeyer (1993) has described it, an approach that is “simultaneously interrogative and therapeutic” (p 230).

7.1.3 A Mutual Orientation Approach to Experimentation

Fundamental to Kelly’s (1955/1991a) personal construct approach was his metaphor of “man-the-scientist” (p 4). By this phrase, Kelly indicated that everyone engages in “scientist-like” behaviour, in that all people, not just scientists, aim “to predict, and thus control, the course of events” (p 12). He also emphasised the cooperative nature of psychotherapy, saying “the client has to be a participant in the experimental venture” (p 53), with the psychologist as a “fellow experimenter.” This approach is encapsulated in Viney’s (1987; 1988) mutual orientation model of
experimentation, in which both experimenter and co-experimenter contribute
something, and gain something, from their endeavour. It is based on an acceptance of
both experimenter and co-experimenter as construing people, with the capacity to
know, and reflect on their own knowledge. When they share their experiences, and
subsequent interpretations, they are both free to express doubts and make mistakes.
This model takes into account the interaction between both parties and assumes that
they respond to and influence one another, that is, “they are influenced both by their
personal interpretations and by what takes place between them” (Viney, 1987, p 44).
Kelly (1955/1991a) suggested, however, that “a therapist-client relationship is one
which exemplifies greater understanding on the part of one member than on the part of
the other. As a therapist comes to subsume the client’s construction system within his
own … it then becomes possible for them to make progress jointly in the social
enterprise” (pp. 96/97). The personal construct therapist has a facilitating role, in the
sense of making easier, or helping bring forward. Kelly’s view was that a good
therapist “does not think of himself as the dictator of what people should be like. His
job is to help people to create new hypotheses and to experiment with them as a means
of growing. He does not tell people what they should eventually be, he only suggests
what they may now try out” (pp. 386/7).

The personal construct approach to experimentation in therapy and groupwork
is also based on Kelly’s position that “the therapist approaches his client’s problem as
the scientist, and invites his clients to do the same” (Kelly, 1963/1969, p 53). Central
to this experimental approach is the use by the therapist of an “invitational mood”
(Kelly, 1969a, p 149). The invitational mood is facilitated by “the language of
hypothesis” (Kelly, 1969a) or of make-believe, “of approaching an event as if some
new construction of it were correct” (Winter, 1992, p 265). For example, a therapist
might suggest “here is a proposition. Let us act as if it were true” (Kelly, 1955/1991b),
thus allowing experimentation beyond existing constructs, “the development and exploration of alternative meanings, can occur alongside of, rather than instead of, existing meanings” (Neimeyer, 1993, p 181). It is an approach that is “more creative than corrective,” that attempts “to foster the broader development of the client’s constructions” (Neimeyer, 1993, p 224). “The only requirement is that the reconstrual effectively cover the facts as the client sees them and provide a viewpoint that offers fresh behavioural alternatives” (Neimeyer, 1988b, p176).

### 7.1.4 A “Credulous Attitude”

Kelly (1955/1991a) considered a “credulous attitude” (p 174), or “credulous approach” (p 322) essential to therapeutic technique. He argued that: “the clinician should maintain a kind of credulous attitude toward whatever the client says” (p 322), stressing that the words and symbolic behaviour of a client “possess an intrinsic truth which the clinician should not ignore” (p 322). Kelly went as far as to say that personal construct psychology is “among other things, a psychology of acceptance” (p 373), and that it “does demand of the psychologist … an acceptance of other persons” (p 373). By this, Kelly was referring to a clinician’s “willingness to see the world through the other person’s eyes” (p 373) and the need to be able to subsume the construct system of a client. Leitner and Faidley (1995) have used the term *optimal therapeutic distance* to describe the best relationship between a therapist and client. They describe it as “being close enough to the other to experience the other’s feelings while simultaneously recognising that they are the other’s feelings - not your own” (p 294).

### 7.1.5 Psychotherapeutic Movement

#### 7.1.5.1 Strategies Described by Kelly

For Kelly (1955/1991b), the processes of therapeutic intervention began with a transitive diagnosis. As I noted in Chapter 3, the construction of a diagnosis that is
transitive acknowledges that a person is engaged in a process of change, and that therapy is concerned with “transitions in the client’s life … bridges between the client’s present and his future” (p 775). Kelly (1969d) believed that: “the task of psychotherapy is not to produce behaviour, but rather to enable the client, as well as his therapist, to utilise behaviour for asking important questions” (p 223). Kelly (1970a) saw behaviour as “man’s principal instrument of inquiry” (p 260), “a question posed in such a way as to commit man to the role and obligations of an experimenter” (p 261).

I briefly summarised some of the other diagnostic dimensions, and concerns, which are important to a personal construct approach to therapeutic movement, in Chapter 3. These included the looseness or tightness of constructs, the dilation or constriction of the perceptual field, the permeability or otherwise of constructs, as well as the validation or invalidation of constructs.

In terms of psychotherapeutic techniques, Kelly (1969b), suggested that “the team of client and therapist can go about the task in the variety of ways” (p 231). He held that “there is no particular kind of psychotherapeutic relationship … nor is there any particular set of techniques that are the techniques of choice for the personal construct theorist … [they] may be as varied as the whole human repertory of relationships and techniques (Kelly, 1969b). He recommended, however, “the clinician should start out by accepting the client’s system in its current form” (p 589).

Working from this standpoint, Kelly (1955/1991b) provided advice about encouraging therapeutic movement through techniques such as interpretation, or “invitations to the client to conceptualize in a new or generalised form” (p 1090). Kelly pointed out that “interpretation … has to be an act of the client rather than an act of the therapist” (p 1102), and cautioned that the therapist should remember that “all interpretations understood by the client are perceived in terms of his own system”
He described strategies to assist a client to extend the range of convenience of a construct, or its applicability, to increase the possibility that “the construct will be utilisable in dealing with brand-new experience - will become more permeable” (p 1090).

Kelly described a further technique, elaboration, to help a client “‘work through’ his construct system” (p 585). Elaboration can relate either to a construct system, client’s complaint, or content arising during therapy, and can be used to produce greater permeability in constructs. Kelly (1955/1991b) gave as an example, a therapist saying to a client: “let us think through how this would be done and how it would turn out in the end” (p 585). Kelly found that “one of the simplest and most effective means of helping the client elaborate material … is by the controlled use of enactment” (p 1025). Enactment can be used to anticipate experiences, demonstrate the permeable use of a construct, and encourage a client “to explore the present implications of the new structure” (p 1091).

Kelly (1955/1991b), also proposed a number of options for the therapist to explore, such as selectively adding new conceptual elements to “add new experience to the client’s life” (pp 589-590), and accelerating “the tempo of the client’s experience” (p 590) through experiences in the therapy room. Other approaches included: imposing recent structures on old elements “because we are always prone to see repetitive themes” (p 591); helping the client “to reduce certain obsolete constructs to a state of impermeability” (p 592), that is, encapsulate certain ideas so that they will only be used in relation to certain past events and figures; acting as a validator of “constructs which cannot be utilised by the client on the outside” of the therapy room, as well as of those which are applicable outside (p 593); and helping design and implement experiments in the therapy room, which Kelly saw as a “laboratory for the testing of ideas” (p 593).
Techniques for therapists to encourage experimentation include: providing clients with a novel situation, thus combining certainty and uncertainty; providing tools of experimentation; and encouraging specific predictions. They also include requesting interpretation of others’ outlooks, for example by enactment, encouraging a client to portray how another person views him or herself, and asking what behaviours will invalidate or validate this. Further techniques that Kelly (1955/1991b) recommended include: encouraging clients to make negative as well as positive predictions; eliciting the conditions under which the client would behave differently; using a direct approach such as “why don’t you do this and see what happens” (p 1134); and providing a social example, such as joining a group.

The attitudinal factors that Kelly (1955/1991b) recommended for encouraging experimentation were permissiveness and responsiveness. Permissiveness removes “the obvious limits upon what the client can say and do” (p 1129), or allows “dilation of the field” (p 1129). Responsiveness is important to experimentation as it provides the client with validational evidence. As Kelly said: “if the client works up his courage to try something, then something should happen as a result of his venture” (p 1129).

7.1.5.2 Strategies Described by Other Personal Construct Clinicians

Epting (1984) argued that it is useful to view the “enterprise of psychotherapy” (p 55) as a complete experience, which can be described in terms of Kelly’s Experience Cycle (1970b). It can therefore be seen in terms of anticipation, investment, encounter, confirmation or disconfirmation, and constructive revision. Epting describes techniques appropriate to each phase of the cycle, for example using self-characterisation or repertory grids in the anticipation phase, when hypotheses are being formed.
Personal construct theorists have described therapeutic processes in various ways (Winter, 1992). Neimeyer (1996), for example, has proposed a taxonomy of 10 process interventions in constructivist psychotherapy, such as empathising, dilating, and contrasting. Viney (1996) has nominated four goals of personal construct therapy. The first of these is making meanings explicit, or helping clients “to become more aware of their own meanings, and the impacts of those meanings in their lives” (p 99). It includes recognising levels of awareness, and acknowledging non-awareness, together with developing an awareness of emotions. A second goal is for client and therapist to develop alternative stories as therapy progresses. A client’s new stories need to be viable, and may be validated by the therapist, whose stories may change in response to the client’s changes. Thirdly personal construct therapy aims for changes in construing and actions, so that interpretations and predictions can be tested. Lastly, therapy should assist clients to develop a wider range of choices of actions, with alternative stories providing rationales for alternative courses of action. Meaning reconstruction is, therefore, the overarching goal of therapy (Harter & Neimeyer, 1995).

Despite the assistance provided by a therapist, it is important to note that from a personal construct perspective the client remains the expert on his or her own meanings. The therapist, however, may help the client to “gain a better verbalisation” (Epting, 1984, p 112), or description, and gain a better understanding of the experience. This approach recognises the importance of relationships, and is based on a respect for the other (Leitner & Faidley, 1995). Finally, a personal construct approach, which regards everyone as a scientist, has a reflexive orientation that “directs the therapist to look in the mirror and apply to her reflection the same constructs that are applied to clients” (Dunnett & Miyaguchi, 1993, p 20).
7.1.6 Summary of the Theoretical Background for Personal Construct Therapy and Groupwork

In Section 7.1 I have summarised some theoretical concepts that form a background for personal construct therapy and groupwork. I have described constructive alternativism, reconstruction as the aim of a personal construct intervention, a mutual orientation approach to experimentation, and essential therapeutic techniques such as approaching a client with a credulous attitude. In addition, I gave an outline of transitive diagnosis, and summarised therapeutic techniques, such as acceptance, interpretation, elaboration, enactment, and strategies for encouraging experimentation. In addition, I referred to strategies described by other personal construct clinicians, such as empathising, and making meanings explicit.

Having described a personal construct approach to therapy, it is important to acknowledge that there is an ongoing debate in psychological literature about the distinctiveness and relative effectiveness of different types of therapy or intervention (Huber, Klug, & von Rad, 2002; Luborsky, Diguer, Luborsky, & Schmidt, 1999; Mahoney, 1995; Neimeyer, 1996; Neimeyer, 1993; Wampold, Minami, Baskin, & Tierney, 2002; Winter & Watson, 1999). Some evidence for the distinctive contribution of personal construct therapy, however, has been provided by research such as that of Winter and Watson (1999), and Viney and Henry (2002).

7.2 Personal Construct Approaches to Groupwork

Personal construct theory encompasses two propositions about interpersonal relationships that are important to personal construct group processes (Viney, 1996). The first is the Commonality Corollary, which states that “to the extent that one person construes an event like another, their psychological processes will be similar” (Kelly, 1955/1991a, p 95). This corollary expresses the concept that people’s psychological
processes will be as similar as their *constructions* of experience are, rather than as similar as their *experiences are*. Cultural, and other social similarities, can be understood in terms of people’s similar constructions of events. Groupwork is useful in providing a setting in which commonality of constructions can be fostered.

The second important proposition is the Sociality Corollary, which states that: “to the extent to which one person construes the construction processes of another, he may play a role in the social process involving another” (Kelly, 1955/1991a, p 95). The importance of this corollary lies in its summation of this concept that “the person who is to play a constructive role in a social process with another person need not so much construe things as the other person does as he must effectively construe the other person’s outlook” (Kelly, 1955/1991a, p 95). Again, groupwork is useful in providing an opportunity for people to accept, and more effectively construe, each other’s ways of seeing things.

Kelly (1955/1991b) argued that the functions of group psychotherapy were broadly the same as those of any other form of psychotherapy, that is, to assist people to more effectively anticipate events. He observed, however, that since human events are a large part of what is to be anticipated, group psychotherapy is particularly useful for improving anticipations of other people. He also identified two other benefits that group therapy offers: giving a “broader initial base … for experimentation and … new role” (p 1156) and a “variety of validational evidence” (p 1157). Viney (1996) observed that groups provide an opportunity to experiment with shared construing, as well as with personal construing.

Personal construct theory approaches to group psychotherapy range from those based on Kelly’s model of group phases (Dunnett & Llewellyn, 1988) to those that have applied personal construct psychology approaches more broadly (Landfield & Rivers, 1975; Neimeyer, 1988a). Winter (1992) argues that a personal construct
approach provides “considerable potential for the further development of a range of
group treatment methods … which are firmly rooted in personal construct theory”
(p.286).

7.2.1 Group Processes

Kelly (1955/1991b) proposed six phases in the development of a psychotherapy
group. The first is the initiation of mutual support, to encourage acceptance and
support between group members. Kelly preferred to use enactment for this phase. The
second phase is the initiation of primary role relationships, with the aim of a person
being able to subsume the construction systems of others. Kelly again uses enactment
for this phase, asking group members to comment, for example, on how a participant
might have felt during the course of the enactment. The third phase is the initiation of
mutual primary enterprises. In this phase, “members of the group use their
understanding of each other to propose and execute experiments” (Kelly, 1955/1991b,
p 1171). This is followed by an exploration of personal problems, so that a team
approach is used to solve problems that are often explored in individual therapy. The
fifth phase is exploration of secondary roles, when group members try to apply their
new insights to situations outside the group room. Finally, the sixth phase is
exploration of secondary enterprises, when group members develop activities that
involve people outside the group. In this final phase, the group functions as a support
for these enterprises, until the groupwork ends (Kelly, 1955/1991b).

Kelly (1955/1991b) emphasised that the phases overlap, and that some sessions
“seem somewhat to exhibit all six phases at once” (p 1160). This description is in
contrast to theories of group formation that rely on a template of group stages to
provide a reassuring framework within which to categorise group events. As Viney
(1996) has noted, personal construct groups “go through cycles of sharing of
construing and individuation of construing,” and it is more accurate to speak not so much of stages, but of “interweaving processes or cycles” (p 155).

Personal construct therapy groups, with their emphasis on continuing experimentation in the outside world, have most often been of a relatively brief duration, with fewer than 20 sessions (Winter, 1992). Personal construct groups also tend to have a maximum of ten members. Dunnett and Llewelyn (1988), for example, used groups with a maximum of 10 members including two leaders or facilitators. Each session was 1½ hours. These therapists described themselves as participant/facilitators: “participant because we too were experimenting albeit at a different personal level; and facilitatory because it seemed the best word to describe the kind of ‘encouragement to elaborate and experiment approach’ that we wanted to foster” (p 188). Koch (1985) suggested that the key role of the therapist is to construe as accurately as possible the construing of group members, and encourage construing that is broader and more abstract than before.

Winter (1992) has pointed out that few subsequent personal construct therapists, with the exception of Dunnett and Llewelyn (1988), have reported using Kelly’s (1955/1991b) highly structured model of group development. Personal construct groups, however, are characterised by the active position of the therapist (Epting, 1984), and a structured approach (Viney, 1996), supported by Neimeyer and Merluzzi’s (1982) finding that a higher degree of structure facilitates therapeutic outcomes. The degree of structure and specification of tasks and processes has, of course, varied from group to group (Winter, 1992).

The Interpersonal Transaction (IT) Groups developed by Landfield and Rivers (1975), for example, used a structured approach. This was adapted and used more loosely by Alexander and Follette (1987). Neimeyer (1988a) elaborated the IT approach, suggesting modifications to group format and processes in response to
common group problems. An IT approach was adapted by Harter and Neimeyer (1995) for a group for incest survivors, and the outcomes for this group were compared with a less structured process group. While both groups showed a positive outcome, there was some evidence that the more structured IT group produced more benefits for group members.

Lovenfosse and Viney (1999) evaluated personal construct group work for mothers who had children with “special needs,” using their “strengths” as part of the processes. They found evidence for a clinically significant increase in life satisfaction after group work for these women, and participants reported that they found the direction provided by the group leader productive. Viney and Henry (2002) compared personal construct with psychodynamic approaches to group work with young offenders, and found that the more structured personal construct approach was more effective in reducing immature behaviours, and that the less structured psychodynamic approach was more effective in promoting mature behaviours. Other groups have also chosen group structures and processes to suit particular client groups, such as high school adolescents (Viney, Truneckova, Weekes, & Oades, 1997) or men diagnosed with HIV (Viney, Allwood, & Stillson, 1991).

7.2.2 Strategies and Factors Helpful for Groupwork

There is an extensive body of research concerning the identification of therapeutic factors, or elements of groupwork that contribute to improvement (Bloch, Reibstein, Crouch, Holroyd, & Themen, 1979; Crouch, Bloch, & Wanlass, 1994). Yalom (1975/1995) made a key contribution to this area, with his identification of 11 primary therapeutic factors in groups. He identified the installation of hope, universality, imparting information, altruism, family recapitulation, socializing techniques, imitative behavior, interpersonal learning, group cohesiveness, catharsis,
and existential factors as therapeutic elements. He regarded interpersonal learning and group cohesiveness as the most important and complex of these factors.

In 1994, Crouch, Bloch and Wanlass reviewed therapeutic factors in group therapy, beginning with studies conducted in the mid-1950s. They found that therapist style was an important aspect of psychotherapy, and that therapist “caring and self-expressiveness” (p 275), was associated with cohesiveness in a group. In personal construct terms, a therapist’s invitational mood and ability to construe the construction processes of others within the group, are important factors for successful groups.

From a personal construct perspective, it is interesting to look at the conclusions that Crouch et al (1994) drew from their survey. Crouch and his colleagues recommended these guidelines for helpful interventions: promoting interaction among group members; creating a safe environment for exploration, including self-disclosure; enhancing cohesiveness by the use of small groups and a “moderately self-expressive and caring style” (p 308); and promoting vicarious learning by encouraging group members to acknowledge similarities among themselves. Each of these factors fits comfortably within, or is, in fact, characteristic of a personal construct therapeutic approach. The personal construct therapist’s “credulous” attitude and invitational mood, the promotion of the group as a safe laboratory for experimentation, and the use of structured dyadic and small group work, all reflect the factors identified above.

Strategies used by personal construct researchers for achieving a positive therapeutic outcome for group participants include commonly used therapeutic strategies (Yalom, 1975/1995) as well as those that are informed by a distinctively personal construct approach. Koch (1985), for example, observed that the disconfirmation of a person’s feeling of uniqueness, which may result from groupwork, is “a powerful source of relief” (p 6). Koch (1985) includes acceptance
and positive regard; taking responsibility for actions; and recurring patterns of validation and elaboration, including searching for commonality and validation, and clarifying differences through reciprocal elaboration. Viney (1996) identified group therapeutic processes as: “opportunities for group members to develop better discrimination, to examine their preemptive or stereotype-like constructs, and to add to their ability to understand the thoughts, emotions, and beliefs of a wider range of other people” (p 154). Group work can also promote dispersion of dependency, rather than the reliance on a limited number of people for support, and provides a setting for the validation or invalidation of members’ constructs, as they test them and gain feedback from a range of people (Viney, 1996). The interdependence of these processes is illustrated by Winter (1992), who observed that “Catina et al (1989) have provided some evidence for their view that clients will reconstrue in response to invalidation of their self-constructions by other group members only if the group is supportive towards them, thus providing them with an overall climate of validation” (p 185).

7.2.3 Evaluating Change

In evaluating whether change has taken place, a personal construct approach takes into account “the individualised criteria of change that focus on personal meanings as much as observable actions” (Neimeyer & Raskin, 2000, p 8/9) and should include “qualitative, process-sensitive measures of human change” (Mahoney, 1991, p 451). As Winter (1992) has proposed, an “appropriate method of investigating therapeutic reconstruction may … be to predict those changes in construing which will reflect a positive treatment outcome for a particular client, and then to monitor these changes over the course of therapy” (p 157).

Burlingame, Kircher and Taylor (1994) reviewed nearly 50 years of methodological critiques and recommendations for conducting group psychotherapy research. They found that during the 1980s and 1990s, there was a growing consensus
that: “it may be necessary to compromise methodological rigour if one is to study natural process-outcome relationships” (p 45). They also found that the importance of using individualised measures of change had been emphasised for nearly 40 years and, in a finding that reinforces Winter’s point, that measures of change should be matched with “the unique goals of treatment, the patients being treated, and the research question” (p 46).

Kelly (1955/1991b) described a number of ways in which a client’s reconstruing during therapy might become apparent. These ranged from the “aha” phenomenon, to the client’s report of new behaviour, or reconstruing revealed in client summaries of treatment sessions. In Chapters 8 and 9, I shall report on measures relating to client construing, and client reports, as important sources of evidence of change for the women in Study 2.

7.3 A Menopause Workshop

In my Study 1, many women described a need for an opportunity to talk about, and resolve, feelings of confusion, an inability to predict what was happening, and a need for change in relation to menopause. This led me to anticipate that development of a Menopause Workshop, based on a groupwork strategy, would be a particularly appropriate response to the needs of these women.

7.3.1 Design and Planning of the Workshop

I designed the workshop to be brief and flexible. There were two reasons for this. Firstly, it was in recognition of the needs of busy women, often fully occupied outside the home. The women, who were predominantly in the paid workforce, did not construe themselves as ill, and were not in search of “therapy” as such. I also recognised that mature women were likely to have to balance work and family responsibilities. Secondly, it was a response to the requirements of future users of the intervention, such as women’s health centres. The rise in healthcare costs, and the
consequent restrictions on healthcare services, is now an important factor to be considered in planning therapeutic interventions (Neimeyer & Raskin, 2000), leading to the growing importance of short-term and time-limited group psychotherapy (Budman, Simeone, Reilley, & Demby, 1994).

A brief workshop was therefore appropriate, given that brief intense interactions have been found to be effective by a number of therapists (Fisher, 2000; Ravenette, 1999; Viney, 1995; Viney, Clarke, Bunn, & Benjamin, 1985). The workshop, although adaptable to more extended delivery, was therefore based on a core number of three sessions of 1½ hours each. This session time was practical in terms of the time commitment for the women, and it has been demonstrated to be an appropriate length for personal construct group sessions (Dunnett & Llewellyn, 1988). The number of women in each workshop was planned to be a maximum of ten, as this also has been found to be appropriate in personal construct groups (Winter, 1992), with their emphasis on interaction and experimentation, and effective in psychotherapy more generally (Yalom, 1975/1995).

I approached the planning and implementation of the Workshop with the Mutual Orientation Model (Viney, 1988) in mind, in the belief that “viewing individuals as active and resourceful participants in their own experiencing patterns can help to empower them in the face of life challenges” (Mahoney, 2000, p 58).

Since the workshop was to be a brief intervention it was important to provide a structured process: (a) to promote therapeutic movement (Neimeyer & Merluzzi, 1982; Viney et al., 1997; Winter, 1992); (b) to avoid the dangers of uncontrolled loosening or tightening (Winter, 1996); and (c) to provide a process to ensure group members could provide alternatives for each other (Winter, 1996). Neimeyer and Merluzzi (1982) have made a strong case for the use of structured process in groups, proposing a systematic information exchange model. They argue that structured process provides
clarity for group members, facilitating systematic information exchange, which in turn can lead to the validation or invalidation of an individual’s construing. This experience may lead group members to reconstrue their predictions in an effort to understand one another, and play a social role in relation to one another. Thus, Neimeyer and Merluzzi (1982) contend, members of a group who construe each other’s construction processes begin to play a social role in relation to each other, resulting in group cohesion, “group cohesion … may be regarded as a direct function of sociality” (p 157).

Short-term interventions also require a high-level of structure in order to maintain the orientation to time and to provide a focus for the group (Budman et al., 1994). Pre-group preparation and the promotion of cohesiveness within the group are crucial. It has been suggested that a degree of homogeneity is helpful for cohesiveness in short-term groups (Budman et al., 1994), despite a wider acceptance that heterogeneity is more generally helpful in therapeutic groups (Winter, 1992; Yalom, 1975/1995).

I also recognised that women would “approach the first session already anticipating some sort of change” (Fisher, 2000, p 436) and that care must therefore “be taken to put the building blocks in place in order to facilitate future reconstruction” (p 436). I explicitly involved women as co-researchers throughout the workshop in order to guard against the processes creating a distance between me, as the researcher, and the participating women (Leitner & Faidley, 1995). I also trusted the women’s ability to choose the degree to which they disclosed their construing, and their “good sense” in avoiding “intolerable levels of negative emotions” (Winter, 1996, p 150), given their knowledge that this was a brief process. I planned the Workshop, however, to focus on limited areas, in recognition that, as Winter (1992) also argues: “it is generally advisable for elaboration of the construct system during therapy to focus on
limited areas, for otherwise the likely result may be a general loosening of the client’s construing” (p 248). I also noted Neimeyer’s advice (1988a) that various environmental conditions, such as working in a group, lack of privacy, bright lighting, and upright seats are conducive to tight construing. As the Workshops were planned for locations of women’s choice, where women were working or studying, these conditions were likely to apply, and provide a control for excessive loosening during the workshop.

I also designed the Workshop recognizing that constructs are not purely verbal, and that those relating to menopause might well be non-verbal. Kelly (1955/1991a; 1955/1991b) observed that constructs may be preverbal or non-verbal, as well as verbal, so that the psychological process of construction is not limited to experiences that can be communicated. Dalton (1993) used this observation with the Circumspection-Preemption-Control (C-P-C) Cycle, explaining that “circumspection may take the form of visualisation or feelings; preemption come as an inward focusing on what is important without full cognitive awareness, and a choice may not be spelled out in our minds at all, but reached at a gut level and then acted upon” (p 106). Balnaves and Caputi (1993) argue that “the assumption of Kelly’s position is that individuals use two semiotic systems” (p 127), one system is verbal and the other represented by preverbal constructs. They note that Kelly proposed that individuals could use signs or symbolic forms to communicate preverbal constructs, and that non-verbal processes such as role-play could be used in therapy to elaborate those constructs.

In recognition of the non-verbal possibilities for construing, I included two activities in the Workshop that allowed the opportunity for non-verbal construing, a drawing activity, and a brief enactment. The three workshop sessions were structured around three major groups of activities. These were planned as a series of explorations
that moved from reflection about the self, to engagement in the C-P-C (decision-making) cycle, and to the dispersion of dependency: women would have an opportunity to consider, and make decisions about, their choices, and develop a wider range of sources of help and support. Next, I provide the content of the three workshop sessions.

7.3.2 Account of the Menopause Workshop

In Session 1 the major activity was writing a self-characterisation (Kelly, 1955/1991a). Because this was written to be seen only by the writer, and each woman chose what she would reveal from it, this activity provided a safe preparation for experimentation. The discussion following focussed on the way a woman could approach menopause, drawing on the positive qualities revealed in the self-characterisation. The compilation of a group list of strengths (Lovenfosse & Viney, 1999) in approaches to menopause followed. The group discussion provided an opportunity for reciprocal elaboration to facilitate clarification of differences, commonality in constructions and relating thinking to that of others (Viney, 1987). Following the validation provided by the compiling of group strengths, the discussion provided the potential for validation or invalidation, and for women to extend the range of convenience of their constructs. The session concluded with a discussion of predictions “what I would like to change,” to assist the development of reality-based hope and self-reliance.

In Session 2 the major activity was drawing a situation and its opposite (Ravenette, 1999), in this case, alternative choices that the women were considering in relation to menopause. This provided women with a novel situation for experimentation to facilitate engagement in the Creativity Cycle. Group and triadic discussion about the preferred choice and support for the choice followed, providing an opportunity for reciprocal elaboration to facilitate circumspection and an
opportunity to engage in the C-P-C decision-making cycle. In the context of the validation provided by the support of the group (Winter, 1992), there was potential for the validation and invalidation of women’s construing, and for the extension of the range of convenience of their constructs.

In Session 3 the major activity was an enactment, verbal or nonverbal (Kelly, 1955/1991a, 1955/1991b), in relation to the second choice identified in the Ravenette activity. This provided opportunities for controlled experimentation in a safe setting. It encouraged the conditions under which the women might begin to behave differently, and for movement and resolution in the C-P-C Cycle. The use of contrasts, or the oppositionality of construing (Rychlak, 1992), is a central concept in Kelly’s (1955/1991a; 1955/1991b) theory, and provides an avenue for a wider exploration of constructs along alternative paths of choice. In this case, the women were invited to enact the contrasting choice to one they had identified in Session 2, so involving their bodies in construction. It was designed to provide access to constructions that had been stored as bodily sensations (Epting & Prichard, 1993), a particularly appropriate method for exploration of construing about menopause, given that, according to Kelly (1970a) “behaviour presents itself as man’s principal instrument of inquiry” (p 260).

Winter (1992) notes that “enactment may be of particular value in that it allows the client to experiment with alternative behaviour but to disengage core constructs from the experimentation by seeing it as only acting a part” (p 250). The enactment was planned as a brief, informal, role-play, designed “to see what it is like … aligned at discovery” (Neimeyer, 1993, p 186) of the alternative choice that women could envisage. Neimeyer has commented that “although brief, these enactments can nonetheless present potent opportunities for discovery, even when they involve little or no actual conversation … Unverbalised casual enactments can be as potent as their verbal counterparts” (1993, p 186). Kelly (1955/1991b) himself pointed out that just
being perceived as being in a certain part is “in itself a form of adventure” (p 1147). A subsequent discussion about choices, and gaining support for choices, provided an opportunity for the dispersion of dependency.

In summary, through the three sessions, women were invited to move through a process of a verbal reflection about the “self now” (self-characterisation) in Session 1; then in Session 2, to a non-verbal activity using images to explore “a sense of self beyond words” (Ravenette, 2001), that looked towards a possible future (drawing choices); and finally, in Session 3, to an activity potentially drawing on pre-verbal construing, using acting, or embodiment, and prediction of a probable future; a verbal-imaging-acting (V-I-A) pathway for movement.

In Chapter 8, I report on, and evaluate, the implementation of the three-session Menopause Workshop with seven groups of women. I follow this, in Chapter 9, by a report of some of the processes of change that occurred during the workshops.
CHAPTER 8

STUDY 2: MENOPAUSE, EMOTION AND RECONSTRUCTION
In this chapter I describe Study 2. This research consists of an evaluation of a brief intervention that took the form of a three-session Menopause Workshop for groups of self-referred women anticipating or experiencing, the menopausal transition. I first present the research framework, aims, theoretical assumptions, and the hypotheses. I follow this account with a description of the sampling, and diagnostic and outcome measures, together with a brief survey of research findings in relation to the measures. Next, I outline the design and procedure of the study, including the procedure for the analysis of the data. The analyses of the data form the final sections of the chapter, which I present in eight sections. There are two main sets of analyses. Firstly, there are those in relation to the samples that took part in the Workshop: Sample A, with levels of distress above the normal range, and Sample B, with levels of distress within the normal range. Secondly, there are the analyses relating to comparisons between the Workshop Samples, and the Contrast Sample, in which the women did not take part in workshops.

8.1 The Research Framework

Study 2, which is reported here, was performed according to the ethical codes of the Australian Psychological Society, the University of Wollongong Human Research Ethics Committee, and the National Statement on Ethical Conduct in Research Involving Humans (National Health and Medical Research Council, 2001).

In addition, however, the study was conducted within a specific research framework, which I have described more fully in Chapter 5, Section 5.1. In summary, the research was based on a personal construct perspective in which the participating women are understood to be co-researchers, and invited to contribute to the interpretation of the research. It was also guided by strategies for cooperative research with women. As I discussed in Chapter 5, the cooperative enterprise allows the freedom to communicate with each other, and the freedom to change (Viney, 1987).
Firstly, consultation was a guiding principle of this study, and the participating women, where possible, were invited to guide decisions. These women were consulted, for example, to ensure that workshops were undertaken at times and places that best fitted into their lives. In addition, this informed the decision to minimise demands on women’s time by offering a brief workshop. Secondly, the facilitation of a context for relationships of trust was important, so that women would experience minimal anxiety about participation, and feel comfortable about taking part in group discussions of potentially sensitive issues. This was important both for ethical reasons, and for achieving psychological gains, particularly in a brief workshop. I anticipated that the use of existing, self-nominated groups would provide a context for relationships of trust, where there would be limited need for group formation and initial anxiety reduction activities.

8.2 Aims: Evaluating a Menopause Workshop

Study 2 was informed by the meanings of menopause identified by women in Study 1, reported in Chapter 5. The themes that were identified in 70% or more of women’s responses in Study 1 were symptoms of menopause, distressing feelings such as anxiety, confusion, and an inability to predict what was happening, and feelings of loss of control over their bodies. The women also identified a need to explore their experience in ways that were more satisfactory than those currently available to many of them.

The overarching aim of the Menopause Workshop was therefore to address those concerns, and the women’s distress, by providing an opportunity for women to share and develop their anticipations and constructions about menopause. The specific aims were: (1) to reduce women’s anxiety and feelings of helplessness in relation to menopause, and (2) to increase women’s feelings of control, hope and positive feelings in relation to menopause.
8.3 Theoretical Assumptions

The theoretical basis for the workshop was provided by a personal construct account of transition and reconstruction in which anxiety, in particular, indicates a need for change, and the Creativity Cycle and the C-P-C Decision-Making Cycle are potential mechanisms of change and reconstruction (Kelly, 1955/1991a, 1955/1991b). As I noted in Chapter 3, Section 3.3.5, Kelly (1955/1991b) called anxiety a “harbinger of change” (p 836), reflecting a lack of adequate structure in the construct system. Anxiety also indicates an opportunity for reconstruction: “invalidating evidence will normally lead to the abandonment of constructs, to anxiety, and thence to revision” (Kelly, 1955/1991a, p 500).

The personal construct model of menopause tested here (Foster & Viney, 2001), and described in Chapter 4, is based on this theory of transition and reconstruction. The three following propositions are derived from the model:

1. When women's existing construct systems are not adequate for successful predictions about menopause, they will become aware of the need for change and experience anxiety;

2. When women have difficulty in engaging in, or completing, the cycles of construction they will not be able to move to creative reconstruction, and will continue to experience anxiety; and

3. When women have opportunities to make elaborative choices and reconstrue themselves in relation to menopause, they are likely to validate their predictions and experience a reduction in anxiety.

In accordance with the model, I argued that shared elaboration of the meanings of menopause, through a Menopause Workshop, would present women with an opportunity for creative reconstruction. This was important in view of the reporting, by the women in Study 1, of a lack of opportunities to explore the meaning of their
experiences at this stage of their lives. I predicted that participation in the Menopause Workshop would reduce the women’s anxiety and other negative feelings, and increase their positive feelings.

As I described in Chapter 3, Kelly (1955/1991b) viewed depression as the effect of attempts to constrict the system and reduce anxiety, so that the revision of constructs is postponed. I argued that a measure of depression could be used to identify those women who were unable to revise their constructs about menopause, and were experiencing higher levels of distress than normal. These women, therefore, should most benefit from an opportunity for reconstruction. Kelly used the example of a menopausal woman to illustrate a case of “involutional melancholia” (p 904), in which a woman experiencing irregular and unpredictable bodily processes, in addition to other midlife problems, might use constriction in the face of confusion and anxiety.

An important theoretical assumption of this study was that data should be collected using a “non-obtrusive” approach (Viney & Caputi, Unpublished paper), appropriate to personal construct research, and that it should reflect the personal meanings of the women involved. I therefore used content analysis scales to identify expressions of emotion in the women’s construing. These measures are described in Section 8.6.

8.4 Hypotheses

H1 Women’s constructions of menopause, as expressed in speech and text samples, will reflect higher than normal levels of distress in a proportion of women greater than that expected in the general population.

H2 When women’s constructions of menopause reflect higher than normal levels of distress they will also reflect higher than normal levels of anxiety, higher than normal levels of feelings of helplessness, and lower than normal levels of feelings of control, hope and positive affect.
If women’s levels of distress are higher than normal, when they have opportunities to reconstrue in relation to menopause, they are likely to experience a reduction in levels of anxiety, a reduction in levels of helplessness, and an increase in feelings of control, hope and positive affect.

8.5 Study 2 Sampling

8.5.1 Sampling

A total of 67 women volunteered for Study 2. Although the use of volunteers affects the generalisation of findings, I found no other method of recruitment to be ethically acceptable. The guidelines of the University of Wollongong Human Research Ethics Committee, in accordance with the National Statement on Ethical Conduct in Research Involving Humans (National Health and Medical Research Council, 2001), emphasise the importance of voluntary participation in research.

Sampling was drawn from the Study 1 Sample (Sample 1), which was a purposive sample directed to women in mid-life and later life, predominantly in paid employment, or in occupations outside the home, and therefore experiencing menopause while in a workplace, or other non-domestic context. The sampling method drew on criterion sampling (Patton, 1990) or judgement sampling (Balnaves & Caputi, 2001) techniques in contacting employed women. Sampling was conducted through Women’s Health Centres, the Older Women’s Network, and a large government department, resulting in a sample of women who were in paid employment, volunteer work, full-time study, or were recently retired from full-time work.

The Study 2 sample was restricted to women within the menopausal age, to ensure the relevance of the workshop to women’s experience. An invitation was sent to Study 1 participants, inviting premenopausal, perimenopausal, and menopausal women to take part in Menopause Workshops in which groups could explore the
meanings of menopause. Twenty-five of the original 74 women volunteered to take part. Since menopausal status is an imprecise notion in the general community, and hormone replacement therapy complicates the identification of that status, all volunteers were accepted, since they were expressing interest in participation. A small number of women, however, identified themselves as immediately postmenopausal. On reflection, it was understandable that postmenopausal women might volunteer. It was clear from the Study 1 results, described in Chapter 5, that menopausal meanings had the power to distress well after the event, even when women were over 70.

These women were joined by an additional 13 volunteers, who had become part of existing work groups that had participated in Study 1, or who heard of the study through the networks used in Study 1 and wanted to make a contribution to the research. This brought the total number of women in the Workshop Sample (Sample 2) to 38.

A further 29 Study 1 women volunteered to take part in two data collections with no workshop. Sixteen of these women completed two data collections, providing a Contrast Sample, Sample C. Thirteen women took part in only one data collection after their interviews, forming Sample D, which therefore could not be used for comparisons with the other samples.
Table 8

Study 2 Samples

Sample 2: Participated in Workshop

Sample 2 total \( (25 + 13) \) \( n = 38 \)

Sample 3: No-Workshop Contrast

(C) Two data collections \( n = 16 \)

(D) One data collection \( n = 13 \)

Sample 3 total \( n = 29 \)

Study 2 total \( n = 67 \)

I acknowledge that the 87 women who took part in the total research project of Studies 1 and 2, all had some level of intervention in that, at a minimum, they took part in a Study 1 interview. In Sample 3 however, after an initial interview, women did not take part in any intervention other than the actual data collection processes. Sample C therefore formed a minimum intervention Contrast Sample for between-group comparisons with the Workshop Sample. It is not described as a control sample in recognition of the fact that there was no random assignment of women to intervention or control samples. Participant characteristics for the samples are given in the following section.

8.5.2 Study 2: Characteristics of the Samples

The characteristics of the 67 women who took part in Study 2 are described in two parts: socio-demographic characteristics and menopausal characteristics. Similarities between the Workshop Sample 2 and Contrast Sample C are shown in Tables 9 and 10. Sample D, from whom data were collected once only, is also
included for comparison. The following characteristics refer to the total sample of women in the study.

8.5.2.1 Socio-Demographic Characteristics

The women who volunteered for this study had an age range from 32 to 79, with a median age of 48 years. The women in Workshop Sample 2 and Contrast Sample C had an age range of 32 to 61, with a median age of 48, and a mean age of 47.4.

In relation to language and cultural background, 74.6% of the sample was of English speaking background, 19.4% were from a non-English speaking background, and 6% were Aboriginal women. This approached the proportions found in the Australian population. There was, however, a slightly higher representation of Aboriginal women, and women from a non-English speaking background, than in the composition of the Australian population in which 16% speak a language other than English at home, 84% speak only English at home, and Aboriginal people make up 2% of the population (Australian Bureau of Statistics, 2000).

The employment status of women in the sample reflected the sampling strategy targeted towards women in employment. Eighty-two percent of the sample was in paid employment, 4.5% were not in paid work but were volunteer workers, 9% were studying, and 3% were recently retired. To put this into the perspective of current employment rates, the Australian labour force participation rate for women is 54.1% and the unemployment rate for women is 5.5% (Australian Bureau of Statistics, 2001).

The Australian Standard Classification of Occupation (ASCO) (Australian Bureau of Statistics, 1998) was used to classify women’s occupations. A summary of the classifications is presented in Appendix B. Women were employed in occupations ranging from the Intermediate Clerical, Sales and Service Worker level to Manager level. The two major occupational classification levels represented in the sample were
65.7% employed at the Professional level and 7.5% at the Intermediate Clerical, Sales and Service Worker level. In the general population, these classifications also represent the occupations with the highest level of women’s participation, however the proportions are quite different: in 1999-2000 20.3% of women were employed at Professional level and 28.2% of women were employed at the Intermediate Clerical, Sales and Service Worker level (Australian Bureau of Statistics, 2000).

The sample differed markedly from the Australian population as a whole in terms of education level, reflecting the employment status of the women. A high proportion of women held a degree, 82.1%, or held a vocational qualification, 10.4%. Of the other women, 3% finished school and 4.5% had not finished school. In the Australian population 10.1% of women hold a Bachelor degree or higher, 6.9% hold an Associate or Undergraduate Diploma, 2.8% hold Skilled Vocational and 3.7% hold Basic Vocational qualifications (Australian Bureau of Statistics, 1996).

Overall, the Workshop and Contrast Samples were closely matched on these characteristics. The samples were compared using non-parametric techniques, and no statistically significant difference was found between the samples on any characteristic other than ethnic and cultural background. Although the majority of women in both samples were from an English speaking background, four women in Contrast Sample C also identified themselves as Aboriginal. No women in the Workshop Sample identified themselves as Aboriginal. There were a higher proportion of women from a non-English speaking background in the Workshop Sample than in Contrast Sample.

The women of Sample D, who took part in only one data collection, were different in two respects from the women in the Workshop Sample and Contrast Sample C. Firstly, in level of education: all of the women in Sample D had a university education. Secondly, in age: the women in Sample D were older than the women in the other samples. This difference in age, and thus possibly the relevance of the study
for them, may well account for the fact that the women in this sample completed only one data collection. Additional factors are discussed in Section 8.5.2.2.

Table 9

*Summary of Participants’ Characteristics: Age, Employment Status, Levels of Employment and Education, and Cultural Background (%)*

<table>
<thead>
<tr>
<th>Sample</th>
<th>Age</th>
<th>Employment status</th>
<th>Level of employment</th>
<th>Level of education</th>
<th>Cultural background</th>
</tr>
</thead>
<tbody>
<tr>
<td>Workshop</td>
<td>Median</td>
<td>Empl’d 81.5</td>
<td>Manager/</td>
<td>Some school</td>
<td>ESB 73.7</td>
</tr>
<tr>
<td>Sample 2</td>
<td>47.5</td>
<td>Study 13.2</td>
<td>Profess’l 65.8</td>
<td>7.9</td>
<td>NESB 26.3</td>
</tr>
<tr>
<td>n = 38</td>
<td>Mean</td>
<td>Retired 5.3</td>
<td>AssProf’l 5.3a</td>
<td>Fin school</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Clerical 10.5</td>
<td>5.3</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Study 13.1</td>
<td>Vocat’l</td>
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<td></td>
<td></td>
<td></td>
<td>Retired 5.3a</td>
<td>college 13.2</td>
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<td></td>
<td></td>
<td>Uni 73.7</td>
<td></td>
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</tr>
<tr>
<td>Contr. Sample C</td>
<td>Median</td>
<td>Empl 87.5</td>
<td>Profes’l 75.0</td>
<td>Vocat’l</td>
<td>ESB 68.8</td>
</tr>
<tr>
<td>n = 16</td>
<td>49</td>
<td>Vol 6.3</td>
<td>AssProf’l 6.2b</td>
<td>College 12.5</td>
<td>NESB 6.2b</td>
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<tr>
<td></td>
<td>Mean</td>
<td>Ret’d 6.2</td>
<td>Clerical 12.6</td>
<td>Uni 85.5</td>
<td>Aborig’l 25.0c</td>
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<td></td>
<td></td>
<td>Ret’d 6.2b</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sample D</td>
<td>Median</td>
<td>Employed 76.9</td>
<td>Manager/</td>
<td>Uni 100</td>
<td>ESB 84.6</td>
</tr>
<tr>
<td>(once only data)</td>
<td>54</td>
<td>Prof 69.2</td>
<td>NESB 15.4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>n = 13</td>
<td>Mean</td>
<td>Volunteer</td>
<td>AssProf’l 7.7b</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>54.15</td>
<td>15.4</td>
<td>Clerical 15.4</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Studying 7.7b</td>
<td>Study 7.7b</td>
<td></td>
</tr>
</tbody>
</table>

\(a\ n = 2; \ b\ n = 1; \ c\ n = 4\)
8.5.2.2 Menopausal Characteristics

As noted earlier, definitions of menopausal status are not precise, particularly in the general community, and are complicated by the use of hormone replacement therapy. Despite this difficulty, women were asked to nominate what stage they thought they were experiencing. Of the total women in Study 2, 43.3% of women defined themselves as premenopausal, 10.4% as perimenopausal, 19.4% as menopausal, and 26.9 as postmenopausal.

The onset of menopause is also an imprecise notion, however women reported onset ranging from 35 to 56, (except in the case of a woman who experienced surgical menopause at 26) with a median age of 47. In relation to the use of medication, overall, 25.4% of women reported using hormone replacement therapy, 13.4% reported using natural therapies, and 61.2% of women reported that they used no medication.

Overall, the Workshop and Contrast Samples were closely matched on these characteristics. The samples were compared using non-parametric techniques and no significant differences were found.

There were two main differences in relation to menopausal characteristics between Sample D, and the women in the other samples. One difference was in menopausal status: more than half of the women in Sample D were postmenopausal. The other difference was in relation to hormone replacement therapy: a greater proportion of the women in Sample D reported using hormone replacement therapy, and none reported using natural therapies. Each of these factors may have contributed to the fact that these women completed only one response to the data collection. Firstly, they were already post-menopausal, and secondly, it appears that they may have made their choices about their courses of action in relation to menopause.
Table 10

*Summary of Participants’ Characteristics: Menopausal Status, Age of Onset, and Medication (%)*

<table>
<thead>
<tr>
<th>Sample</th>
<th>Meno status a</th>
<th>Age onset a</th>
<th>Medication</th>
</tr>
</thead>
<tbody>
<tr>
<td>Workshop</td>
<td>Pre 55.3</td>
<td>Median 47.5</td>
<td>HRT 15.8</td>
</tr>
<tr>
<td>Sample 2</td>
<td>Peri 13.2</td>
<td>Mean 46.9</td>
<td>Nat. 18.4</td>
</tr>
<tr>
<td>n = 38</td>
<td>Meno 15.8</td>
<td>None 65.8</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Post 15.8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contrast</td>
<td>Pre 37.5</td>
<td>Median 47.5</td>
<td>HRT 31.3</td>
</tr>
<tr>
<td>Sample C</td>
<td>Peri 6.3</td>
<td>Mean 45.7</td>
<td>Nat. 12.5</td>
</tr>
<tr>
<td>n = 16</td>
<td>Meno 25.0</td>
<td>None 56.3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Post 31.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sample D</td>
<td>Pre 15.4</td>
<td>Median 47.0</td>
<td>HRT 46.2</td>
</tr>
<tr>
<td>n = 13</td>
<td>Peri 7.7</td>
<td>Mean 46.3</td>
<td>None 53.8</td>
</tr>
<tr>
<td></td>
<td>Meno 23.1</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Post 53.8</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

\(^a\) Not a precise measure: Women’s estimate.

8.5.3 The Workshop Groups

The women nominated the membership of workshop groups, usually on the basis of existing work groups. Seven groups were formed, and the number of women in each ranged from 3 - 8. Workshops were carried out at locations chosen by the women, most often at their workplaces. A Kruskal-Wallis test showed no statistically significant difference between the seven Menopause Workshop Groups on any of the dependent variables at Time 1. The workshops took place between 6 December 2000 and 5 June 2001. Data collection extended for five months after each workshop.
The Workshop Leader was a mature-age, registered psychologist, with a background in personal construct psychology.

8.5.4 Workshop Structures and Processes

I have described the tasks and processes of the Menopause Workshop in Chapter 6. The theoretical context for the workshop was that content should be generated and explored by participants, but the format would be structured to promote therapeutic movement (Neimeyer & Merluzzi, 1982; Winter, 1992; Viney, Henry & Campbell, 1996). Each workshop session was structured around a major group of activities. In summary, the major activity in Session 1 was a self-characterisation (Kelly, 1955/1991a), followed by a discussion about ways the women could approach menopause, drawing on the positive qualities revealed in their self-characterisations. In Session 2, the major activity was drawing a situation and its opposite (Ravenette, 1999) in relation to a choice women were facing. Discussion about the preferred choice and support for the choice followed.

The major activity in Session 3 was an enactment (Kelly, 1955/1991a, 1955/1991b) in relation to the second choice identified in the Ravenette activity. The final activities were a discussion about choices and predictions, followed by a further discussion about gaining support for those choices.

8.5.5 Workshop Patterns of Participation

As I made clear in Section 7.3, the Menopause Workshop was designed to be brief and flexible, to meet the needs of busy women with multiple responsibilities, and women were able to nominate their preferred pattern of participation. The Workshop was designed on a base of three major activities that could be delivered as a whole day workshop, or three separate sessions over time. Five groups nominated three consecutive sessions, and two groups nominated a whole day workshop.
8.6 Measures

In this study, content analysis scales were used as quantitative tools to assess psychological states, and provide scaled measurement of text analyses. They allowed statistical inferences to be drawn from data. Content analysis techniques have been used since the 1950s by a variety of disciplines, such as linguistics and psychology, for both qualitative and quantitative analyses (Gottschalk, 1979a; Gottschalk, 1986; Gottschalk, Lolas, & Viney, 1986). In psychology, content analysis has been concerned with meaning, rather than form, and has, for example, “explored the relationship between linguistic phenomena and the clinical impression of affect” (Gottschalk & Gleser, 1969, p. 8).

Content analysis can provide a method of identifying themes or processes, however it does not, of itself, allow complex statistical analysis. There is, therefore, an important distinction to be made between content analysis as such, and content analysis scales, which are a means for providing a quantitative summary of verbal communication (Viney, Caputi, & Webster, 2000), or allowing quantitative inferences to be made from verbal communication (Lolas, 1986). Content analysis scales provide rigorous, scaled measurement, as well as meanings.

Gottschalk and Gleser (1969) pioneered the development of content analysis scales in the U.S.A. In 1969, these researchers published a number of content analysis scales, based on psychodynamic theory, for use in clinical psychology and psychiatry. Since that time, Gottschalk and his colleagues have published many successful validational, and other, studies related to the scales (Gottschalk, 1979a; Gottschalk, 1979; Gottschalk, 1979b). In 1986, they added a further scale, the Depression Scale (Gottschalk & Hoigaard, 1986). In Australia, Viney and her colleagues developed a series of content analysis scales with personal construct psychology as their base

The development of content analysis scales involves a series of steps that have been outlined by Gottschalk (1979b) and Viney (Viney, 1983; 2000). There are nine steps in the process: describing and defining a psychological state; defining the unit of content to be analysed; specifying the content of verbal communications from which the state is to be inferred; specifying any cues to demonstrate the intensity of the state; applying differential scoring weights to the cues; including a scaling factor to correct for the number of words used; deriving a total score, or set of subscores; examining the distributions of scores, and transforming, when necessary, for greater normality; collecting normative data from specified samples (Viney & Caputi, Unpublished paper).

The most recent developments of content analysis scales are the addition of computerised methods of scoring, or computer supported scoring techniques. A method of computerised scoring for the American scales has been developed (Gottschalk & Bechtel, 1990), and Viney, Caputi & Webster (2000) have devised a method of computer supported scoring for the Australian scales.

Computer systems of the analysis of speech content not only provide a considerable saving in time, but also increase the uniformity of the content analysis scale applications (Gottschalk & Bechtel, 1990). In 1990, Gottschalk and Bechtel (1990) reported that interscorer reliability between automated and human scoring was in the range of 0.80 and above for most scales.

The usefulness of content analysis scales for non-intrusive assessment of psychological states has been demonstrated in many studies (Gottschalk & Bechtel, 1990; Viney, 1993; Viney, 1998). In 1980, Viney used content analysis scales with women in Australia to assess psychological states in a range of stages across the
lifespan, including with a group of women aged between 46 and 58 years, providing Australian data relevant to this study.

Content analysis scales have been used to measure change, such as that occurring during the processes of therapy (Gottschalk, 1979; Gottschalk & Bechtel, 1990), and have been used successfully in a variety of studies predicting and evaluating therapeutic outcome (Gottschalk, 1979a; Gottschalk, 1986; Lolas, Kordy, & von Rad, 1986; Truneckova & Viney, 1997; Viney, 1998; Viney, Benjamin, & Preston, 1989; Viney, Clarke, Bunn, & Benjamin, 1985; Viney & Henry, 2002; Viney et al., 1997).

Content analysis scales can be applied to different kinds of language materials. Although it is common to apply the method to interview material (Gottschalk, 1979a), it has also been demonstrated that it can be applied reliably to written material (Gottschalk & Bechtel, 1990), and that “repeated speech samples may be obtained, without notable practice effects, hours, days, or weeks apart” (Gottschalk, 1979b, p 7).

When content analysis scales are used with recorded oral verbalisations, non-verbal cues may be lost. In this study some of this loss was reduced by the use of written communications. Women frequently used capital letters or other forms of emphasis in their responses. This could be used as an guide when scoring the Viney and Westbrook scales with the Analyse computer supported system, because a scorer personally scores the clauses, but it could not be taken into account with the fully computerised Gottschalk scales (Foster & Viney, 2001; Viney et al., 2000).

Winter (1992) has argued that content analysis scales are theoretically appropriate for personal construct psychology researchers. They provide “assessment that is centered on the personal meanings of clients” (Viney, 1993) and a way of measuring “the flow of peoples’ experience without interfering with it” (Viney, 1983). Content analysis scales allow the measurement of verbal material gained through an
interrogative approach more usual to qualitative analyses. They “make possible a non-
obtrusive and ethical approach to both clients and therapists” (Viney & Caputi,
Unpublished paper, p 36), while providing an opportunity for people to talk about what
is important to them. Content analysis scales are, therefore, appropriate for the
personal construct assumptions underlying this study.

8.6.1 The Content Analysis Scales Used to Assess Distress, Anxiety,
Feelings of Helplessness, Control, Hope and Positive Feelings

Content analysis scales were used in this study to measure negative feelings
linked with times of transition, positive feelings that indicate validation of choices, and
to predict the women who should benefit most from the opportunity for reconstruction,
by screening the women for levels of distress. Two sets of content analysis scales were
used: (a) Australian scales developed by Viney and Westbrook, the Cognitive Anxiety
Scale (Viney & Westbrook, 1976) (anxiety), the Origin and Pawn Scales (Westbrook
& Viney, 1980) (control and helplessness, respectively) and the Positive Affect Scale
(Westbrook, 1976) (positive feelings); and (b) American scales developed by
Gottschalk and colleagues, the Hope Scale (Gottschalk & Gleser, 1969) (hope); and the
Depression Scale (Gottschalk & Hoigaard, 1986) (distress).

The Gottschalk-Hoigaard Depression Scale (Gottschalk & Hoigaard, 1986) was
used as a diagnostic and predictive measure. It is based on a psychiatric diagnostic
system, but it assesses a range of disruptive and distressing states (Viney, 1983), and
was used in this study as a measure of distress. The scale includes subscales scoring
hopelessness, self-accusation, psychomotor retardation, somatic concerns, death and
mutilation depression, separation depression and hostility outward. An example of a
coded transcript is included in Appendix L. The scale is strong in identifying somatic
and related concerns. The occurrence of depression within or above the normal range
was determined using norms set for the scale (Gottschalk & Bechtel, 1990), that is, one
standard deviation above the norm as a distinguishing point for depression above the normal range.

Within a personal construct framework, the Depression Scale was an appropriate measure of distress, in the light of Kelly’s (1955/1991b) view of depression as an indicator of an attempt to constrict the system to diminish anxiety, so that the revision of constructs is postponed. I therefore used the Depression Scale to discriminate between women who were unable to revise their constructs about menopause, and were experiencing higher levels of distress than normal, and those who were not. The more distressed women, therefore, should most benefit from the opportunity for reconstruction. In addition, the strength of the scale in identifying somatic concerns was useful, given the concerns women expressed about physical symptoms, reported in Chapter 5, and the emphasis on these in the menopausal literature, reported in Chapter 2.

The key outcome measure in this study was anxiety. In Study 1, reported in Chapter 5, I had identified uncertainty, and an inability to predict what would happen, as major themes in women’s meanings of menopause. Anxiety was, therefore, particularly relevant to the women in this study. It is also more widely acknowledged that women’s anxiety and uncertainty about the menopausal transition is an issue for concern. In the medical literature on menopause, uncertainty has been identified as an important issue to be addressed by intervention programs (Lemaire & Lenz, 1995; O'Connor et al., 1998).

In this study, I assessed anxiety using the Cognitive Anxiety Scale (Viney & Westbrook, 1976), a scale measuring uncertainty, a concept identical to the personal construct concept of anxiety, that is, the recognition that events lie outside one's construct system. The scale measures Cognitive Anxiety experienced by the self, or others, as a result of: novel stimuli (‘I'm not used to doing that’); unavailable
responses (“I did not know what to do”); extra constructs needed (“You get things you don't expect”); incongruous stimuli (“It was a strange experience”); and high rate of stimulus presentation (“It’s a bit bewildering”). An example of a coded transcript is included in Appendix K.

To complement the Cognitive Anxiety Scale in measuring, within a personal construct framework, women’s feelings about menopause, I used additional scales measuring feelings of helplessness and control, hope and positive feelings.

The Pawn Scale (Westbrook & Viney, 1980) was used to measure women’s feelings of helplessness. It identifies whether self indicates that he or she did not intend an outcome (“I did not plan to quit work”); self indicates that he or she did not try to bring about an occurrence (“I was not trying to fix it, but when I bumped it, it started to go”); self expresses lack of ability, describes self as powerless, incapable, a failure (“I just couldn't help it”); self describes as being controlled, forced, prevented, at the mercy of other forces (“He would not let me take the children”); and self perceived as pawn, events are described as unpredictable or uncontrollable (“the sickness struck me”). An example of a coded transcript is included in Appendix K.

The Origin Scale (Westbrook & Viney, 1980) measures feelings of control. It identifies instances when self expresses intention, says that he or she planned or mentions plans, purposes or goals (“I planned the party”); self expresses exertion or trying, describes his or her efforts to achieve some desired result (“I'm trying to find out”); self expresses ability, comments on his or her skill, competence (“I'm managing very well”), self expresses overwhelming or influencing others or the environment (“I did not let that stop me”); and self perceived as cause or origin (“I took control when the accident happened”). An example of a coded transcript is included in Appendix K.

The Pawn and Origin Scales (Westbrook & Viney, 1980) were used as an indication of whether women were having difficulty engaging in, or completing the
Decision-Making Cycle, that is, difficulty considering choices, and making choices, during a time of menopausal change, or whether they were experiencing feelings of control. The Origin Scale, measuring women’s feelings of control in their experience or expectation of menopause, was an indication of whether they felt able to deal with changes relating to menopause. The scale has previously been used in a similar fashion, when it was used as a competence scale, to measure the degree to which people feel able to deal with threat of death (Viney, 1993).

Feelings of hope and positive feelings were also measured by scales appropriate within a personal construct framework. The Hope Scale (Gottschalk & Gleser, 1969) was devised: “to measure the intensity of optimism that a favorable outcome was likely to occur” (p 247). There are seven content categories, four of which are weighted positively. The first four categories are references to “(1) self or others getting or receiving help, advice, support, sustenance, confidence, esteem (a) from others (b) from self; (2) feelings of optimism about the present or future (a) others (b) self; (3) being or wanting to be or seeking to be the recipient of good fortune, good luck, God’s favor or blessing (a) others (b) self; (4) any kinds of hopes that lead to a constructive outcome, to survival, to longevity, to smooth-going interpersonal relationships” (Gottschalk & Gleser, 1969, p 247). Three further categories are weighted negatively. These are references to “(5) not being or not wanting to be or not seeking to be the recipient of good fortune, good luck, God’s favor or blessing; (6) self or others not getting or receiving help, advice, support, sustenance, confidence, esteem (a) from others (b) from self; (7) feelings of hopelessness, losing hope, despair, lack of confidence, lack of ambition, lack of interest, feelings of pessimism, discouragement (a) others (b) self” (Gottschalk & Gleser, 1969, p 247). An example of a coded transcript is included in Appendix L.
The Positive Affect Scale (Westbrook, 1976) identifies instances when the self directly expresses positive affect ("I was happy, thrilled, excited, delighted, pleased, overjoyed"); descriptions of situations or events that imply that self has experienced positive affect ("It's good to have my own apartment"); descriptions of others that imply that self has experienced positive affect ("My husband is wonderful"); and statements that imply that self has experienced positive affect, but do not clearly fall in the above categories ("It has been well and truly worth it"). Positive Affect is not scored for relief when an unpleasant event has stopped, nor is the word "good" scored, when it refers to a job well done, moral behaviour or health. An example of a coded transcript is included in Appendix K.

It has been found that the Positive Affect Scale taps positive feelings associated with happy, enjoyable experiences (Viney et al., 2000). In the case of illness, Viney (1986) reported that the scale can be used as an indication of "the sense of competence implicit in coping" (Viney, 1986, p 221). The Hope Scale (Gottschalk & Gleser, 1969), and the Positive Affect Scale (Westbrook, 1976), designed to measure positive states, were used as an indication that women were currently satisfied with the choices of construction that they were making, and as an indication that their choices had been validated.

The Depression Scale was used to test Hypothesis 1: Women’s constructions of menopause, as expressed in speech and text samples, will reflect higher than normal levels of distress in a proportion of women greater than that expected in the general population.

The Cognitive Anxiety Scale (Viney & Westbrook, 1976), the Pawn and Origin Scales (Westbrook & Viney, 1980), the Hope Scale (Gottschalk & Gleser, 1969), and the Positive Affect Scale (Westbrook, 1976), were used to test Hypothesis 2: When women’s constructions of menopause reflect higher than normal levels of distress they
will also reflect higher than normal levels of anxiety, and helplessness, and lower than normal levels of feelings of control, hope, and positive affect. They also test Hypothesis 3: If women’s levels of distress are higher than normal, when they have opportunities to reconstrue in relation to menopause, they are likely to experience a reduction in levels of anxiety, and helplessness, and an increase in feelings of control, hope, and positive affect.

In addition, these scales were used to test Workshop Aim (1) to reduce women’s anxiety, and feelings of helplessness, in relation to menopause; and Workshop Aim (2) to increase women’s feelings of control, hope, and positive feelings in relation to menopause.

8.6.1.1 Psychometrics of the Scales

Reliability will be discussed in terms of three types: interjudge reliability, internal consistency, and stability. Content, criterion, and construct validity will then be examined.

In the measurement of transitory states, such as emotions, *interjudge reliability* is the most important criterion of reliability of a scale. It indicates the consistency with which the scale can be used by independent raters, and therefore the consistency with which interpretations of verbal communications can be made (Viney, 1983; Viney et al., 2000). Correlation coefficients for interjudge reliability on the Australian scales have been summed over many sets of data (Viney, 1983; Viney & Westbrook, 1976; Westbrook, 1976; Westbrook & Viney, 1980). Although Cognitive Anxiety Scale coefficients can sometimes be as low as .71 (Viney et al., 2000), the average coefficient for all of the scales is .90 or above (Viney et al., 2000), indicating good reliability.

In this study, interjudge reliability on scoring the Australian scales was tested on a sample of cases with satisfactory results. A random sample of 30% of participants
was generated using an SPSS random sample program. The transcripts from this sample were given to independent raters who examined them and coded them according to the instructions for the scales. Two independent raters scored each scale. Coding results of the independent raters and the researcher were investigated. Pearson’s product-moment correlation coefficients were calculated resulting in correlation coefficients of more than .82 in all cases. A table of results is presented in Appendix M. In addition, t-tests were calculated to compare the raters’ scores for each scale. No significant difference between raters was shown.

The American scales have also been demonstrated to have good interjudge reliability (Gottschalk, 1986; Gottschalk & Bechtel, 1990). As these scales, however, were scored electronically using PCAD 2000: Psychiatric content analysis and diagnosis (Gottschalk & Bechtel, 1990), it was not necessary to conduct interjudge reliability tests for this study.

Internal consistency is an aspect of reliability related mainly to sets of scales, and is therefore more relevant to the American scales in this study. Internal consistency is not reported as such for the Depression or Hope Scales. In a discussion of criterion validity, Gottschalk and Hoigaard (1986) report that in a comparison of Depression Scale test items and test items from three other standard measures of depression, intercorrelations of test items from the measures provide a “coherent, consistent, and plausible picture of the theoretical construct” (p 118). This indicates that the Depression Scale is likely to be internally consistent, to the extent that the other tests are internally consistent. The Hope scale is reported to have similar characteristics (Gottschalk, 1979).

Stability of scores over time, as a measure of reliability, is only relevant for scales that measure relatively stable states. Scores on the Cognitive Anxiety Scale have been demonstrated to show a fairly high degree of stability (Viney & Westbrook,
1976), as have scores on the Pawn Scale (Westbrook & Viney, 1980). The Origin Scale assesses potentially variable psychological states, and scores show low stability (Westbrook & Viney, 1980). Similarly, the Hope Scale assesses variable psychological states (Gottschalk, 1979). There is no available data on the stability of Positive Affect Scale, or Depression Scale scores.

The validity of the scales can be assessed by examining information about the relationships between the scales and other indices. A content analysis scale is likely to have inherent content validity since the content comes directly from the participant in the research, as long as the categories consistently represent the intended content (Viney, 1983). Correlation with other measures of the same construct or with other content analysis scales, provide concurrent criterion-based validity. In addition, discrimination by the scales of groups of participants, or situations experienced by them, can also be used to establish criterion-based validity (Viney, 1983). Construct validity is assessed by examining whether scales respond appropriately when tested in new situations (Gottschalk & Gleser, 1969; Viney, 1983). Validity is now considered in relation to each scale.

Scores on the Cognitive Anxiety Scale are independent of gender and age but higher scores are related to higher occupational status. Scores are related to other negatively toned measures (Viney & Westbrook, 1976) and discriminate people in situations that are new to them (Viney, 1980), and people’s accounts of situations that were unpredictable from those that were not (Viney & Westbrook, 1976). They occur in both patients and staff dealing with change in a mental health service (Winter, 1990). Scores on the scale have been shown to be responsive to personal construct group work with adolescents, with a decrease immediately after group work, but not maintained at follow up (Viney, Henry, & Campbell, 1999).
The Pawn Scale (Westbrook & Viney, 1980) assesses the extent to which people perceive their actions to be shaped by forces beyond their control, and the Origin Scale (Westbrook & Viney, 1980) assesses the extent to which people perceive their actions to be determined by their own choices. The two scales are “related conceptually but, empirically speaking, are independent” (Viney & Westbrook, 1986, p 160), with no significant relationship between the scales consistently demonstrated (Westbrook & Viney, 1980).

Pawn Scale scores are independent of gender and age but higher scores are related to lower occupational status (Westbrook & Viney, 1980). They are significantly correlated with other negatively toned measures (Westbrook & Viney, 1980). They discriminate those who are ill and unemployed from those who are not (Westbrook & Viney, 1980), and they predict patterns of gain from therapy (Viney et al., 1989). Scores on the scale have been shown to be responsive to therapy with older people, (Viney et al., 1989) and people who are ill (Viney, 1990; Viney, Clarke, Bunn, & Benjamin, 1985). In both cases there was a decrease in scores after therapy, and this was maintained at follow up.

Origin Scale scores are independent of gender and age, but higher scores are related to higher occupational status. They are related to other positively toned measures (Westbrook & Viney, 1980). They discriminate those who are experiencing controllable events from those who are not, youth workers from their clients (Viney, 1981), and those who have psychologically healthy dying from those who have less psychologically healthy dying (Viney, Walker, Robertson, Pincombe, & Ewan, 1994). The scores have also predicted outcome variables such as physical state and use of medical services (Viney, Clarke, Bunn, & Teoh, 1985). Scores on the scale have been shown to be responsive to therapy with older people, (Viney et al., 1989), and people who are ill (Viney, 1990; Viney, Clarke, Bunn, & Benjamin, 1985). In both cases
there was an increase in scores after therapy, and this was maintained at follow up at three months, and 12 months later, respectively.

Hope Scale scores are independent of gender, age and educational level. They are significantly negatively correlated with measures of negatively toned states, and significantly positively correlated with measures of other positively toned states (Gottschalk, 1979). Scores have discriminated medical patients leaving hospital from those staying (Gottschalk & Gleser, 1969), and the scores predict favorable outcomes among patients in a mental health clinic (Gottschalk, 1979).

Positive Affect Scale scores are independent of gender, age, education, and occupational status. They are related to other positively toned measures (Westbrook & Viney, 1980). Positive Affect Scale scores discriminate women moving to a new home (Viney & Bazeley, 1977) and women giving birth (Viney, 1980). Scores on the scale have been shown to be responsive to therapy with older people (Viney et al., 1989), with an increase in scores after therapy, which was maintained at the three month follow up. They have also been shown to be responsive to personal construct group work with adolescents, with an increase immediately after group work, but this was not maintained at the six-month follow up (Viney et al., 1999).

Depression Scale scores have been found to be significantly positively correlated with other standard measures of depression (Gottschalk & Hoigaard, 1986). Scores on the scale have been shown to discriminate alcoholic males, depressed outpatients, and hyperactive children (Gottschalk & Hoigaard, 1986).

8.6.2 Participants’ Evaluations

An evaluation sheet was designed to elicit feedback from women after the workshop. It was anonymous in order to control for any effect related to the researcher, such as participants providing information that is perceived as favorable for the researcher (Miles & Huberman, 1994). Women were asked for general comments
on the Workshop, and which sessions of the Workshop were helpful. They were also asked for recommendations about the preferred number of sessions in the Workshop. The Participant Evaluation Sheet is shown at Appendix N.

8.7 Design

In order to test all of the hypotheses, an outcome study was conducted using a repeated measure, contrast group design. Content analysis scales were used to assess the level of emotion reflected in women’s construing about menopause at three data collection times: pre-workshop, post-workshop, and after a period of five months. At the first data collection the women in Sample 2 were screened using their scores on the Gottschalk-Hoigaard Depression Scale (Gottschalk & Gleser, 1969), which was used as a diagnostic and predictive measure of distress. Women with scores above the norm were assigned to Sample A (Above average), and women with scores within the normal range were assigned to Sample B (Normal), in a screening process.

In addition, a further Contrast Sample (Sample C) was formed, to examine change in the Workshop Samples over a five-month period. As described in 8.5.1, Study 1 women, who had not volunteered for the workshop, were invited to take part in two data collections, which paralleled the pre-workshop and five-month post-workshop data collections of the Workshop Samples. There was no attempt to collect data three times from Contrast Sample C, as in some cases women in the Workshop Samples opted for a one-day workshop, and the pre-workshop and immediate post-workshop data collections took place on the same day. It would have been meaningless, and onerous for Sample C women, to collect data twice on one day with no workshop.

In accordance with my research framework, women were not assigned to either the Workshop or Contrast Samples by randomisation, but rather on the basis of their preference. This decision was made in order to provide a research context for
relationships of trust where women would feel comfortable discussing potentially sensitive and important issues (Holmes, 2002). The screening as part of this design, however, should provide helpful information for future use of these workshops. The ethical issues underlying this aim were reflected in a recent study (Featherstone & Donovan, 2002), which points out that, although randomised controlled trials are the acknowledged standard for evaluating the effectiveness of treatments, little is known about how and why patients decide to participate in trials, nor how much they understand about trial design. The findings from the study showed that “most eligible patients, whatever their level of knowledge, will struggle to make sense of their participation in randomised trials,” with resulting feelings ranging through trust, struggle and cynicism (Featherstone & Donovan, 2002, p 709). From a statistical point of view, despite the fact that randomisation of subjects represents the standard for research, some researchers have observed that randomisation may not result in the equivalence of small samples, as it can produce unbalanced distributions in experiments with a small number of subjects (Hsu, 1992).

In Study 2 there was an assumption that since the samples of women were drawn from the same Study 1 population, that they would be matched in terms of socio-demographic characteristics. I recognise the problem of generalising findings from a purposive volunteer sample such as this, and that the Contrast Sample provides a basis for comparison only, rather than acting as a randomised experimental control sample.
Table 11

*Participation of Samples in Data Collections*

<table>
<thead>
<tr>
<th>Sample</th>
<th>Data collections</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pre-workshop</td>
</tr>
<tr>
<td>Sample 2 assigned to:</td>
<td>yes</td>
</tr>
<tr>
<td>A (above norm) or</td>
<td></td>
</tr>
<tr>
<td>B (within normal range)</td>
<td></td>
</tr>
<tr>
<td>C (Contrast)</td>
<td>yes</td>
</tr>
<tr>
<td>D (one response)</td>
<td>yes</td>
</tr>
</tbody>
</table>

Dependent variable data were obtained by analysis of women’s responses to an open-ended question in relation to menopause, to be described in Section 8.8, asked at each of the data collections times. Content analysis scales yielded scores that were used to measure individual change in women’s feelings of anxiety, helplessness, control, hope, and positive affect.

8.8 Procedure

8.8.1 Information and Consent

Before the workshop began all women were asked to read the Information Sheets giving an outline of the project and advice that they may withdraw from the research at any time without negative consequences (Appendix C). Women were asked to sign a Consent Form indicating their willingness to participate in the project and were given contact details of the relevant University of Wollongong person for them to contact if they had concerns or questions (Appendix D).
8.8.2 Confidentiality

A subject number was used for identification purposes in relation to written data. Women were advised of the need to respect confidentiality when in a workshop, and were advised that confidentiality is dependent on the commitment of each participant. The researcher gave an undertaking not to disclose any information given in the course of the research in any way that could identify a participant.

8.8.3 Data Collection: Sample 2

A seven-part data collection process was undertaken in this study.

Part 1: Prior to the commencement of workshop activities, I conducted two data collection procedures to establish baseline data.

(a) New participants were asked to complete a short questionnaire requesting age, age at onset of menopause if applicable, current or past treatment for menopause, and type of employment if applicable, that Study 1 women had already completed (see Appendix E). In addition, all women were asked two socio-demographic questions relating to educational qualifications and use of medication.

(b) All women were also asked to respond to an open-ended question:

“Please would you describe your life at the moment in relation to menopause, the good things and the bad - what it's like for you?” (see Appendix O).

This procedure was designed to provide baseline data, for analysis by content analysis scales, to determine levels of emotion.

This study used email as a means of minimising the demands on women. All women were asked if email was an appropriate way to communicate with them. It proved to be a very popular choice. Six of the seven groups preferred this method of communication and gave their consent in writing. As all women made their responses in writing, all responses were seen as comparable, whether in hard copy form, or email. Women were able to email their responses directly to the researcher, ensuring that they
could respond at a time most convenient to them within the constraints of the research requirements. Five of the seven groups participated in the workshop at their workplace location, so this method of communication was a practical, convenient and appreciated strategy.

Part 2: During the Workshop, I recorded my construing, and my construing about the women’s responses, on a “Diary” Record Sheet (Appendix P).

Part 3: (a) After the workshop, the women involved were invited to complete an anonymous evaluation of it (Appendix N). (b) Women were again asked to write a response to the open-ended question asked before the workshop: “Please would you describe your life at the moment in relation to menopause, the good things and the bad - what it's like for you?” (Appendix O).

Part 4: Five months after participation in the workshop, women were asked to respond for a third time to the open ended question that was asked previously. This data collection provided time lapse data.

8.8.4 Data Collection: Sample C

Part 5: The women from Contrast Sample C were asked to respond to the same open-ended question that was asked of the women from Samples A (Above average), and B (Normal).

Part 6: After a period of five months the women from Contrast Sample C were asked to respond again to the same question.

Part 7: Women were advised of the findings and asked for their comments.

8.8.5 Administration of workshop

A detailed outline of the workshop procedure is included in Appendix I. Handouts (HOs) were provided to women throughout the workshop as noted in the outline. Copies of all handouts are included in Appendix J. Throughout the workshop,
women were invited to guide decision-making on issues such as whether they preferred a discussion to take place in dyads or with full group participation.

8.8.6 Analyses of Data

Hypothesis 1 predicted that women’s constructions of menopause would reflect higher than normal levels of distress, in a proportion of women greater than that expected in the general population. In relation to the Workshop Sample (Sample 2), a Chi-squared Goodness-of-fit test was used to determine whether women whose constructions of menopause reflected higher than normal levels of distress were in a proportion greater than that expected in the general population.

Hypothesis 2 proposed that when women’s constructions of menopause reflect higher than normal levels of distress, they would also reflect higher than normal levels of anxiety and feelings of helplessness, lower than normal levels of feelings of control, hope and positive affect. I tested this by calculating the mean and standard deviation for women with levels of distress above the normal range (Sample A) on each scale, at Time 1, and comparing these to norms for the scales.

Hypothesis 3 predicted that if women’s levels of distress are higher than normal, when they have opportunities to reconstrue in relation to menopause, they are likely to experience a reduction in levels of anxiety and helplessness, and an increase in feelings of control, hope and positive affect. In order to test this hypothesis, I conducted a series of analyses. Firstly, I examined whether differences occurred between and within Samples A (Above average distress), and B (Within the normal range distress): pre-workshop, post-workshop, and after a five-month period. Secondly, I examined whether differences occurred between and within Samples A (Above average), and B (Normal), and C (Contrast) over the five-month period.
The following analyses were carried out.

1. A repeated measures analysis of variance to investigate differences in Cognitive Anxiety Scale (anxiety) scores between Samples A (Above average), and B (Normal), and within the samples. If a significant interaction between time and sample was shown, this was followed by a separate repeated measures analysis of variance for each sample.

2. A repeated measures multivariate analysis of variance to investigate differences in Pawn and Origin Scale scores between Samples A (Above average), and B (Normal), and within the samples. If a significant interaction between time and sample was shown, this was followed by a separate repeated measures analysis of variance for each dependent variable (Pawn or Origin Scale scores); followed, if significant, by a separate repeated measures analysis of variance for each sample (Sample A or B).

3. A repeated measures multivariate analysis of variance to investigate differences in Hope and Positive Affect Scale scores between Samples A (Above average), and B (Normal), and within the samples. If a significant interaction between time and sample was shown, this was followed by a separate repeated measures analysis of variance for each dependent variable (Hope and Positive Affect Scale scores); followed, if significant, by a separate repeated measures analysis of variance for each sample (Sample A or B).

4. The tests outlined in (1), (2) and (3) above, were conducted for Samples A (Above average), and B (Normal), and C (Contrast).
8.9 Findings from Study 2

8.9.1 Incidence of Distress by Sample

On the basis of the model of menopause proposed in Chapter 2, I argued that women’s constructions of menopause would reflect higher than normal levels of distress, in a proportion of women greater than that expected in the general population. Verbal communications from the women were analysed to test this prediction. The Time 1 data collection was immediately pre-workshop for the Workshop Sample (Sample 2), and the first follow-up after the interview for Contrast Sample C. The scores were analysed by group using the Gottschalk-Hoigaard Depression scale as a measure of distress. The occurrence of depression within or above the normal range was determined using norms set for the scale (Gottschalk & Bechtel, 1990). Frequency of scores falling above the norm are as follows.

Table 12

<table>
<thead>
<tr>
<th>Sample Description</th>
<th>Percent</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sample 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interview plus workshop</td>
<td>52.0%</td>
<td>13/25</td>
</tr>
<tr>
<td>Workshop only</td>
<td>53.9%</td>
<td>7/13</td>
</tr>
<tr>
<td>Total Sample 2 (Workshop)</td>
<td>53.0%</td>
<td>20/38</td>
</tr>
<tr>
<td>Sample 3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interview plus two follow-ups</td>
<td>12.5%</td>
<td>2/16</td>
</tr>
<tr>
<td>Interview plus one follow-up</td>
<td>46.2%</td>
<td>6/13</td>
</tr>
<tr>
<td>Total Sample 3 (Contrast)</td>
<td>27.6%</td>
<td>8/29</td>
</tr>
</tbody>
</table>

The sample with the highest percentage of women whose scores occurred above the norm for distress was Sample 2, consisting of women who volunteered for
the Workshop. In total, 53% of women who took part in the workshop had levels of
distress that were more than one standard deviation above the norm. This result is
consistent with studies that show that “discomfort is a necessary prerequisite for an
individual to subject himself to the painful process of seeking help for personal
problems” (Perley, 1979).

Hypothesis 1 predicted that women’s constructions of menopause would reflect
higher than normal levels of distress, in a proportion of women greater than that
expected in the general population. A Chi-squared Goodness-of-fit test was used to
determine whether women whose constructions of menopause reflected higher than
normal levels of distress, were in a proportion in this sample, greater than that expected
in the general population. The result was found to be statistically significant, \( \chi^2 (1, n = 38) = 38.47 \), using an alpha level of .05, confirming Hypothesis 1.

8.9.2 Workshop Participants and Levels of Distress

The women in Workshop Sample 2 were divided into two sub-samples on the
basis of their levels of distress, measured by the Gottschalk-Hoigaard Depression
Scale, so that responses to the workshop could be compared. Sample A (Above
average) (n = 20) was composed of women whose scores were above the normal range;
and Sample B (Normal) (n = 18) was composed of women whose scores were within
the normal range.

8.9.3 Sample A (Above Average) and Levels of Emotion

Hypothesis 2 proposed that when women’s constructions of menopause reflect
higher than normal levels of distress, they would also reflect higher than normal levels
of anxiety, and levels of feelings of helplessness, lower than normal levels of feelings
of control, hope, and positive affect. Sample A (Above average) was therefore tested
as follows.
8.9.3.1 Anxiety, Helplessness, Feelings of Control, Hope, and Positive Feelings

Means and standard deviations were calculated for Sample A (Above average) scores on the Cognitive Anxiety, Pawn, Origin, Hope and Positive Affect Scales for Time 1, and compared to norms for the scales (See Table 13).

Table 13

Means and Standard Deviations for Sample A (Above average) on Content Analysis Scale Scores

<table>
<thead>
<tr>
<th>Scale</th>
<th>Mean</th>
<th>St. Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognitive Anxiety</td>
<td>3.70</td>
<td>.90</td>
</tr>
<tr>
<td>Australian Norm a</td>
<td>1.19</td>
<td>.63</td>
</tr>
<tr>
<td>Pawn</td>
<td>2.23</td>
<td>.61</td>
</tr>
<tr>
<td>Australian Norm a</td>
<td>.84</td>
<td>.25</td>
</tr>
<tr>
<td>Origin</td>
<td>1.83</td>
<td>.56</td>
</tr>
<tr>
<td>Australian Norm a</td>
<td>.63</td>
<td>.24</td>
</tr>
<tr>
<td>Hope</td>
<td>-.49</td>
<td>1.88</td>
</tr>
<tr>
<td>American Norm b</td>
<td>.73</td>
<td>1.03</td>
</tr>
<tr>
<td>Positive Affect</td>
<td>1.06</td>
<td>.45</td>
</tr>
<tr>
<td>Australian Norm a</td>
<td>.84</td>
<td>.42</td>
</tr>
</tbody>
</table>

a (Viney, 1980)
b (Gottschalk, Hausmann, C., & Brown, J.S., 1979)

Results showed that scores for Sample A, with higher levels of distress, reflected higher than normal levels of cognitive anxiety, and feelings of helplessness, and lower than normal levels of Hope, as predicted in Hypothesis 2. The standard deviation of scores was also greater than the norms, indicating greater variability in these scores than in the Australian norms. Results did not confirm that Sample A scores reflected lower than normal levels of feelings of control and positive affect,
rather, this group showed higher than normal levels on the Origin and Positive Affect scales. In addition, for the Origin Scale, the standard deviation for this sample was greater than the Australian norm, indicating greater variability in these scores than in the Australian norms. This result may reflect the sampling in this study as it has been found that higher scores on the Origin and Positive Affect scales are related to higher occupational status (Westbrook & Viney, 1980).

8.9.4 Workshop Samples: Analysis of Data

In order to test Hypothesis 3, I conducted a series of analyses to examine whether differences occurred between and within Samples A (Above average), and B (Normal): pre-workshop, post-workshop, and after a five month period.

The retention rate was very high. All Time 1 women in Samples A (Above average), and B (Normal), took part in the Time 2 data collection, and 37 out of 38 initial women took part in that for Time 3. It was impossible to contact one participant from Sample A (Above average) at Time 3, despite repeated attempts. Participation at Time 3 was Sample A (Above average) n = 19 and Sample B (Normal) n = 18. I therefore conducted the following analyses with n = 19 for Sample A (Above average).

As a number of tests are included in the analyses, \( \alpha = .01 \) was used rather than \( \alpha = .05 \), in order to reduce the risk of Type 1 error (Tabachnick & Fidell, 1989). In the interests of accuracy, p values are therefore reported to three decimal places where necessary.

Prior to all tests, preliminary assumption testing was conducted to check for normality, and univariate and multivariate outliers with no serious violations noted. Homogeneity of variance-covariance matrices were tested using Box’s Test of Equality of Covariance Matrices with non-significant results indicating no violation of assumptions.
Cognitive Anxiety Scale scores

I conducted a repeated measures analysis of variance to investigate differences in anxiety scores between, and within, Samples A (Above average), and B (Normal), over time. The dependent variables were Cognitive Anxiety Scale scores on three data collection occasions. The independent variable was membership of Sample A or B. No significant main effect for sample, or interaction effect for time and sample was found. Within-subjects, there was a statistically significant main effect shown for time (pre-workshop and post-workshop and at five-month follow-up): $F(2,34)= 19.81, p < .01; \text{Wilks' lambda} = .46; \text{partial eta squared} = .54$, with an observed power of 1.00. The differences shown were therefore within-sample, rather than between samples, at all data collection times.

Eta-squared ($\eta^2$) is a measure of the relationship between the independent variable and the dependent variable(s) in a set of sample data. Although the relationship between the variables is stronger as eta-squared approaches 1.00, some statisticians argue that the interpretation of eta-squared depends on the context of the research (Jaccard & Becker, 1997; Singer, Lovie, & Lovie, 1986), and relatively small values of eta-squared may be common in the behavioural sciences. Jaccard and Becker (1997), for example, propose that in that context, a robust interpretation would interpret an eta-squared less than .20 as representing a weak relationship, an eta-squared of between .20 and .50 as representing a moderate relationship, and an eta-squared greater than .50 as representing a strong relationship between variables (Jaccard & Becker, 1997). In this study, partial eta squared is calculated to overcome concerns raised about eta squared as a measure of effect size (Stevens, 1996; Tabachnick & Fidell, 1989). The importance of the level of power of a test is also context dependent, however, a power of .80 or above is considered desirable (Jaccard & Becker, 1997).
I then considered Samples A (Above average), and B (Normal), separately, to explore the effect for Time.

**Sample A (Above average)**

There was a statistically significant reduction in mean scores between Time 1, and Times 2, and 3: $F(2,17) = 15.20, p < .001$, Wilks’ lambda = .36. A strong effect was indicated by partial eta squared = .64, with an observed power of 1.00. Within-subjects contrasts indicated that there was a significant reduction in mean scores between Time 1 ($M = 3.67, SD = .89$), and Time 2 ($M = 2.27, SD = .87$), $p < .001$, and Time 1 and Time 3 ($M = 2.70, SD = .93$), $p < .01$.

**Sample B (Normal)**

There was a statistically significant reduction in mean scores over time: $F(2,16) = 6.33, p < .01$, Wilks’ lambda = .56, partial eta squared = .44, with an observed power of .83. Within-subjects contrasts indicated that there was a reduction in mean scores that approached significant difference, between Time 1 ($M = 3.52, SD = 1.34$) and Time 2 ($M = 2.87, SD = .72$), $p = .015$, and that there was a significant reduction in mean scores between Time 1 and Time 3 ($M = 2.58, SD = .77$), $p < .01$.

In summary, for Sample A (Above average), the mean score for Cognitive Anxiety Scale scores at Time 1 was significantly different, and higher, than those at Times 2 and 3, indicating that the post-workshop reduction in mean scores was maintained after a period of five months. For Sample B (Normal), on the Cognitive Anxiety Scale, there was a reduction in mean scores between Times 1 and 2 that approached significant difference, and a significant reduction in mean scores between Time 1 and Time 3. These findings indicate that a post-workshop reduction in mean scores was increased after a period of five months.

A graph of mean Cognitive Anxiety Scale Scores, for Samples A (Above average), and B (Normal), on three occasions, is shown here in Figure 2. The graph
shows, for both samples, the significant reduction in anxiety scores five months after the workshop, despite a slight rise in scores over time in Sample A.

Figure 2. Mean Cognitive Anxiety Scale Scores for Samples A (Above average), and B (Normal), on three data collection occasions

8.9.4.2 Control and Helplessness

I conducted a repeated measures multivariate analysis of variance to investigate differences in Pawn and Origin Scale scores between Samples A (Above average), and B (Normal), and within the samples over time. The dependent variables were Pawn Scale scores, measuring feelings of helplessness, and Origin Scale scores, measuring feelings of control, on the three occasions. The independent variable was membership of Sample A (Above average), or B (Normal).

No significant main effect for sample, or interaction effect for time and sample was found. Within-subjects, there was a statistically significant main effect shown for time (pre-workshop and post-workshop and at five-month follow-up) on the combined
dependent variables: $F (4,32)= 9.33, p < .001$, Wilks’ lambda = .46; partial eta squared = .54, with an observed power of 1.00. The differences shown were therefore within-sample, rather than between samples, at all data collection times.

I then considered Samples A (Above average), and B (Normal), separately, to explore the effect for Time. A separate repeated measures analysis of variance was performed for each measure. Simple contrasts, in which the means for Times 2 and 3 were compared to Time 1, were used to investigate whether a difference occurred over time in each sample. In each case the dependent variables were scores at Times 1, 2, and 3.

(a) Pawn

**Sample A (Above average)**

There was a statistically significant result for the Pawn Scale scores: $F (2,17) = 6.75, p < .01$, Wilks’ lambda = .56, partial eta squared = .44, with an observed power of .86. Within-subjects contrasts indicated that there was a statistically significant reduction in mean scores between Time 1 ($M = 2.23, SD = .61$), and Time 2 ($M = 1.57, SD = .36$), $p < .01$. Although the reduction in mean scores between Time 1, and Time 3 ($M = 1.82, SD = .51$), was not significant at $\alpha = .01$, it approached significance at $p = .026$.

**Sample B (Normal)**

There was a statistically significant result for the Pawn Scale scores: $F (2,16) = 12.29, p < .01$, Wilks’ lambda = .39. A strong effect was indicated by partial eta squared = .61, with an observed power of .99. Within-subjects contrasts indicated that there was a statistically significant reduction in mean scores between Time 1 ($M = 2.14, SD = .58$), and Time 2 ($M = 1.61, SD = .52$), $p < .001$, and Time 1, and Time 3 ($M = 1.61, SD = .50$), $p < .01$. 
(b) Origin

Sample A (Above average)

There was no statistically significant result for the Origin Scale scores at $\alpha = .01$. Results, however, approached significance: $F(2,17) = 4.78, p = .023$, Wilks’ lambda = .64, partial eta squared = .36, with an observed power of .72. Within-subjects contrasts indicated a statistically significant increase in mean scores between Time 1 ($M = 1.83, SD = .56$), and Time 2 ($M = 2.30, SD = .42$), $p < .01$.

Sample B (Normal)

There was no statistically significant result for the Origin Scale scores at $\alpha = .01$. Results again approached significance: $F(2,16) = 5.42, p < .02$, Wilks’ lambda = .60, partial eta squared = .40, with an observed power of .77.

In summary, a statistically significant main effect was shown for time within-subjects for Pawn and Origin Scale scores. That is, there was a difference in scores within samples, but no difference was shown between samples. For Pawn Scale scores in Sample A (Above average), there was a statistically significant reduction in mean scores between Time 1, and Time 2, indicating a reduction post-workshop. Time 1 scores were not significantly different from those at Time 3 at $\alpha = .01$, but the difference approached significance. For Pawn Scale scores in Sample B (Normal), there was a statistically significant reduction in mean scores between Time 1, and Times 2, and 3, indicating that a post-workshop reduction in scores was maintained after a period of five months. For Origin Scale scores, no contrasts between times were significant for either sample at $\alpha = .01$, however results for both samples approached significance. Graphs of the Pawn and Origin scale scores are shown in Appendix Q.
8.9.4.3 Hope and Positive Affect

I conducted a repeated measures multivariate analysis of variance to investigate differences in Hope and Positive Affect Scale scores between Samples A (Above average), and B (Normal), and within the samples over time. The dependent variables were Hope and Positive Affect Scale scores on the three occasions. The independent variable was membership of Sample A (Above average) or B (Normal).

No significant main effect for sample, or interaction effect for time and sample was found. Within-subjects, there was a statistically significant main effect for time (pre and post-workshop and at five-month follow-up), on the combined dependent variables: $F(4,32)= 10.50, p < .001$; Wilks’ lambda = .43. A strong effect size was indicated by partial eta squared = .57 (Jaccard & Becker, 1997), with an observed power of 1.00. The differences shown were therefore within-sample, rather than between samples, at all data collection times.

I then considered Samples A (Above average), and B (Normal), separately, to explore the effect for Time. A separate repeated measures analysis of variance was performed for the Hope Scale, and the Positive Affect Scale. Simple contrasts, in which the means for Times 2 and 3 were compared to Time 1, were used to investigate whether a difference occurred over time in each sample. In each case the dependent variables were scores at Times 1, 2, and 3. The independent variable was membership of Sample A (Above average) or B (Normal).

(a) Hope

Sample A (Above average)

There was no statistically significant result for the Hope Scale scores at $\alpha = .01$. Results, however, were very close to significance: $F(2,17) = 5.40, p = .015$, Wilks’ lambda = .61, partial eta squared = .39, with an observed power of .77. Within-subjects contrasts indicated that there was a statistically significant increase in mean
scores between Time 1 (\(M = -.49, SD = 1.90\)), and Time 2 (\(M = 2.41, SD = 2.99\)), \(p < .01\).

**Sample B (Normal)**

There was no statistically significant result for the Hope Scale scores at \(\alpha = .01\). Results, however, also approached significance: \(F (2,16) = 5.14, p = .019\), Wilks’ lambda = .61, partial eta squared = .39, with an observed power of .74. Within-subjects contrasts indicated that there was a statistically significant increase in mean scores between Time 1 (\(M = .48, SD = 2.41\)), and Time 2 (\(M = 2.24, SD = 2.95\)), \(p < .01\). The mean score for Time 1 was not significantly different from Time 3 at \(\alpha = .01\) \((p = .047)\).

**b) Positive Affect**

**Sample A (Above average)**

There was no statistically significant result for the Positive Affect Scale scores at \(\alpha = .01\). Results, however, were also very close to significance: \(F (2,17) = 5.57, p < .015\), Wilks’ lambda = .60, partial eta squared = .40, with an observed power of .78. Within-subjects contrasts indicated that there was a statistically significant increase in mean scores between Time 1 (\(M = 1.06, SD = .45\)), and Time 2 (\(M = 1.55, SD = .58\)), \(p < .01\).

**Sample B (Normal)**

There was a statistically significant result for the Positive Affect Scale scores in this sample: \(F (2,16) = 10.97, p < .01\), Wilks’ lambda = .42. A strong effect was indicated by partial eta squared = .58, with an observed power of .97. Within-subjects contrasts indicated that there was a statistically significant increase in mean scores between Time 1 (\(M = 1.13, SD = .52\)), and Time 2 (\(M = 1.48, SD = .50\)), \(p < .01\). The mean score for Time 1 was not significantly different from Time 3.
In summary, a main effect was shown for time within-subjects for Hope and Positive Affect Scale scores. That is, there was a difference in scores within samples, but no difference was shown between samples. When the measures were considered separately, for the Hope Scale the increase in scores over time was very close to significance for Sample A \( (p < .015) \) and approaching significance for Sample B \( (p < .019) \). Within-subjects contrasts for Samples A and B indicated a difference between the mean scores for Times 1 and 2.

For Positive Affect Scale scores, in Sample A (Above average), results showed that the increase in scores over time was very close to significance \( (p < .015) \). Within-subjects contrasts indicated an increase in the mean scores between Times 1 and 2. For Sample B (Normal), there was a statistically significant difference between the mean scores over time. Within-subjects contrasts indicated that there was a statistically significant increase in mean scores between Time 1 and Time 2.

The results for the Hope and Positive Affect Scale scores in both samples showed that, although increases in scores were shown between Time 1, pre-workshop, and post-workshop at Time 2, this increase was not maintained at the same level at Time 3, after a period of five months. Graphs of the Hope and Positive Affect scale scores are shown in Appendix Q.

8.9.4.4 Summary of Results for Samples A (Above average) and B (Normal)

In Sample A (Above average), there was a statistically significant reduction for Cognitive Anxiety and Pawn Scale scores, between Time 1, pre-workshop, and Time 2, post-workshop. There was also a statistically significant increase in Positive Affect Scale scores between Times 1 and 2. There was evidence, which was very close to significance, of an increase in Hope Scale scores, and some evidence of an increase in Origin Scale scores. After a period of five months, the reduction was maintained for
the Cognitive Anxiety Scale scores, with the reduction in Pawn Scale scores
approaching significance at $p = .026$. No other difference in scores was maintained.

In Sample B (Normal), a significant difference was shown between Time 1 and
Time 2 scores for the Pawn and Positive Affect Scales, with the difference in
Cognitive Anxiety Scale scores close to significance. There was also some evidence,
which approached significance, of an increase in Hope and Origin Scale scores. After
a period of five months, at Time 3, the reduction in scores was maintained for the
Pawn Scale, and the reduction became significant for Cognitive Anxiety Scale scores.
No other difference in scores was maintained.

Hypothesis 3, which related only to Sample A (Above average), was only
partially confirmed. At Time 2 there was significant, and close to significant, evidence
to confirm the proposition stated in Hypothesis 3 in regard to that sample. By Time 3
however, there was significant evidence of a longer term change in levels of emotion
only in relation to anxiety, measured by the Cognitive Anxiety Scale. A reduction in
feelings of helplessness, measured by the Pawn Scale, was significant only in Sample
B (Normal).

The women of Sample A (Above average), showed a significant long term
decrease in anxiety, and a long-term decrease in feelings of helplessness that
approached significance at .026. Although there was significant short-term
improvement in relation to positive measures, this was not sustained after five months.

In an unexpected result, however, participation in the Workshop also appeared
to produce beneficial results for the women in Sample B (Normal), those women
whose initial distress was within normal levels. There were statistically significant
long-term reductions in anxiety and feelings of helplessness for these women, plus a
significant short-term increase in Positive Affect Scale scores, and close to significant
short-term increases in Origin and Hope Scale scores. A set of graphs for all dependent variable scale scores may be found at Appendix Q.

Table 14

*Summary of Significant Results for Samples A (Above average), and B (Normal),*

<table>
<thead>
<tr>
<th>Scales</th>
<th>Sample</th>
<th>Effect for time</th>
<th>Contrasts times 1 &amp; 2</th>
<th>Contrasts times 1 &amp; 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognitive Anxiety</td>
<td>A</td>
<td>$p &lt; .001$</td>
<td>$p = .001^a$</td>
<td>$p &lt; .01$</td>
</tr>
<tr>
<td></td>
<td>B</td>
<td>$p &lt; .01$</td>
<td>$p &lt; .015^a$</td>
<td>$p &lt; .01$</td>
</tr>
<tr>
<td>Origin</td>
<td>A</td>
<td>$p = .023^a$</td>
<td>$p &lt; .01$</td>
<td></td>
</tr>
<tr>
<td></td>
<td>B</td>
<td>$p &lt; .02^a$</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pawn</td>
<td>A</td>
<td>$p &lt; .01$</td>
<td>$p &lt; .01$</td>
<td>$p = .026^a$</td>
</tr>
<tr>
<td></td>
<td>B</td>
<td>$p &lt; .01$</td>
<td>$p &lt; .001$</td>
<td>$p &lt; .01$</td>
</tr>
<tr>
<td>Hope</td>
<td>A</td>
<td>$p = .015^a$</td>
<td>$p &lt; .01$</td>
<td></td>
</tr>
<tr>
<td></td>
<td>B</td>
<td>$p &lt; .02^a$</td>
<td>$p &lt; .01$</td>
<td>$p = .047^a$</td>
</tr>
<tr>
<td>Positive Affect</td>
<td>A</td>
<td>$p = .014^a$</td>
<td>$p &lt; .01$</td>
<td></td>
</tr>
<tr>
<td></td>
<td>B</td>
<td>$p &lt; .01$</td>
<td>$p &lt; .01$</td>
<td></td>
</tr>
</tbody>
</table>

$^a$ Included to provide full information. Although result is not significance at $\alpha = .01$, it approaches significance.

8.9.5 *Contrast Sample C: Analysis of Data*

Sample 3 women, after an initial interview, did not participate in any further intervention, other than the actual data collection processes. Sixteen Sample 3 women took part in two data collections five months apart (Times 1 and 3), but did not take part in a Menopause Workshop (Sample C). An additional 13 women took part in only one data collection after their interviews (Sample D).

The five month period between data collections for Sample C paralleled the five month period between pre-workshop and post-workshop follow-up data.
collections for Workshop Samples A (Above average) and B (Normal). The 16
women of Sample C were therefore used to provide a Contrast Sample for the women
in the Workshop Samples A (Above average), and B (Normal).

In order to examine whether differences occurred between and within Samples
A (Above average), B (Normal), and C (Contrast), between Time 1 and Time 3, over a
five month time period, I conducted three analyses of variance with membership of
Samples A, B, and C, as the independent variable, and as dependent variables:

1. the Cognitive Anxiety Scale scores, on two occasions;
2. the Pawn and Origin Scale scores on two occasions;
3. the Hope Scale, and the Positive Affect Scale scores, on two occasions.

8.9.5.1 Measure of Anxiety

I conducted a repeated measures analysis of variance to investigate differences
in anxiety scores between Samples A (Above average), B (Normal), and C (Contrast)
and within the samples over time. The dependent variable was Cognitive Anxiety
Scale scores at Times 1 and 3. The independent variable was membership of Sample
A, B, or C.

_Cognitive Anxiety Scale scores_

A statistically significant interaction effect was shown for time and sample: \( F (2,50)= 9.18, p < .001; \) Wilks’ lambda = .73; partial eta squared = .27, with an
observed power of .97. A statistically significant main effect for time was also shown:
\( F (2,50)= 14.40, p < .001; \) Wilks’ lambda = .78; partial eta squared = .22, with an
observed power of .96.

To explore the interaction effect, I tested time and sample separately. Firstly, I
tested differences between samples by performing a one-way analysis of variance for
each time. At Time 1, a statistically significant difference was shown between
samples: \( F = (2,50) = 10.61, p < .001. \) At Time 3, there was no significant difference
between samples, indicating that any initial difference between samples was no longer present five months after the workshop.

I then considered Samples A (Above average), B (Normal), and C (Contrast) separately to test change within the samples over time. I conducted a repeated measures analysis of variance for each sample. In each case the dependent variable was Cognitive Anxiety Scale scores at Times 1 and 3. The independent variable was membership of Sample A, B, or C.

**Sample A (Above average)**

There was a statistically significant reduction in scores between Time 1 ($M = 3.67, SD = .89$), and Time 3 ($M = 2.70, SD = .93$), for Sample A (Above average): $F(1,18) = 16.42, p < .01$, Wilks’ lambda = .52, partial eta squared = .48, with an observed power of .86.

**Sample B (Normal)**

There was a statistically significant reduction in scores between Time 1 ($M = 3.52, SD = 1.34$), and Time 3 ($M = 2.58, SD = .77$), for Sample B (Normal): $F(1,17) = 13.42, p < .01$, Wilks’ lambda = .56, partial eta squared = .44, with an observed power of .77.

**Sample C**

There was no statistically significant difference shown between means for Times 1 and 3 in Sample C.

In summary, for Cognitive Anxiety Scale scores, results for Samples A (Above average), and B (Normal), showed that there was a significant reduction in Cognitive Anxiety Scale scores between pre-workshop and post-workshop data collection occasions. There was, however, no difference between times for Sample C. The analyses showed that there were significant differences between samples at Time 1. By Time 3, following a period of five months after the workshop, the differences
between Samples C (Contrast) and Samples A (Above average), and B (Normal), were no longer present. These results indicate that the Workshop may have had an effect in reducing the higher levels of anxiety that were shown initially in the Workshop Samples.

8.9.5.2 Measures of Helplessness and Control

I also conducted a repeated measures multivariate analysis of variance to investigate differences in Pawn and Origin Scale scores between Samples A (Above average), B (Normal), and C (Contrast) and within the samples over time. The dependent variables were Pawn Scale scores at Times 1 and 3, and Origin Scale scores at Times 1 and 3. The independent variable was membership of Sample A, B, or C.

No significant interaction effect was found between sample and time at α = .01. There was a significant main effect for sample: $F (4,98) = 7.67, p < .001$, Wilks’ lambda = .58, partial eta squared = .24, with an observed power of 1.00. There was also a significant main effect for time: $F (2,49) = 6.91, p < .01$, Wilks’ lambda = .78, partial eta squared = .22, with an observed power of .91.

I then investigated the effects for time and sample for each measure separately, using a repeated measures analysis of variance. In each case the two dependent variables were scores at Times 1 and 3. The independent variable was membership of Sample A (Above average), B (Normal), or C (Contrast).

(a) Pawn Scale

A statistically significant main effect was shown for time: $F (1,50) = 13.07, p < .01$; Wilks’ lambda = .79; partial eta squared = .21, with an observed power of .94. There was no difference between samples.

I then undertook further tests to explore the effects for time in each sample. Samples A (Above average), B (Normal), and C (Contrast) were considered separately,
using a repeated measures analysis of variance. The dependent variables were Pawn Scale scores at Times 1 and 3.

Sample A (Above average)

There was no statistically significant difference between the means for Time 1 and Time 3, for Sample A (Above average), at $\alpha = .01$, however results approached significance at $p < .03$.

Sample B (Normal)

There was a statistically significant reduction in scores between Time 1 ($M = 2.14, SD = .58$), and Time 3 ($M = 1.61, SD = .50$), for Sample B (Normal): $F(1,17) = 11.83, p < .01$, Wilks’ lambda = .59, partial eta squared = .41, with an observed power of .70.

Sample C (Contrast)

There was no statistically significant difference shown between means for Times 1 and 3 in Sample C.

(b) Origin Scale scores

For Origin Scale scores, there were no significant differences shown between samples, or between Times 1 and 3.

In summary, for measures of helplessness and control, Pawn Scale scores in Sample B (Normal) showed a significant reduction between scores pre-workshop at Time 1, and five months later, at Time 3. There was also some evidence of a difference in Pawn Scale scores over time in Sample A (Above average). No difference was shown for Contrast Sample C. These results indicate that the Workshop may have had an effect in reducing the levels of helplessness in the Workshop Samples. No significant difference was shown between samples, or over time, for Origin Scale scores.
8.9.5.3 Measures of Hope and Positive Affect

I conducted a repeated measures multivariate analysis of variance to investigate differences in Hope and Positive Affect Scale scores between Samples A, B and C and within the samples over time. The dependent variables were Hope and Positive Affect Scale scores at Times 1 and 3. The independent variable was membership of Sample A, B, or C.

No significant interaction effect was found for sample and time on the combined dependent variables. There was a statistically significant main effect for Time: \( F(2,49) = 11.17, p < .001; \) Wilks’ lambda = .69; partial eta squared = .31, with an observed power of .99.

I then investigated the effect for time for each measure separately, using a repeated measures analysis of variance. In each case the dependent variables were scores at Times 1 and 3.

(a) Hope Scale scores

No significant interaction effect was found for sample and time. There was a statistically significant main effect for time: \( F(1,50) = 13.37, p < .01; \) Wilks’ lambda = .79; partial eta squared = .21, with an observed power of .95.

I then explored the effects for time in each sample, considering Samples A (Above average), B (Normal), and C (Contrast) separately, using a repeated measures analysis of variance. The dependent variable was Hope Scale scores. There was no statistically significant difference shown between means for Times 1 and 3 in Samples A, B, or C.

(b) Positive Affect Scale scores

No significant results were shown.

In summary, for measures of hope and positive affect, there was a statistically significant main effect shown for time in relation to Hope scores, but when means for
Times 1 and 3 were tested in each sample, results did not attain statistical significance. It is possible, however, that the small sample sizes were a factor in producing this non-significant result (Stevens, 1996).

8.9.5.4 Summary of Results of Analyses Including the Contrast Sample C

The key measures that distinguished between Workshop Samples A (Above average), and B (Normal), and C (Contrast), were measures of anxiety, and helplessness. Within-Sample reductions in Cognitive Anxiety Scale scores, in Workshop Samples A (Above average), and B (Normal), were not shown in Contrast Sample C, indicating that significant change occurred in the Workshop Samples, but not in Contrast Sample C. In addition, differences between samples at Time 1, for Cognitive Anxiety Scale scores, were not present five months after the workshop at Time 3, indicating that a significant change occurred for the Workshop Samples.

In relation to measures of helplessness and control, a significant reduction was shown in Sample B, between Pawn Scale scores, pre-workshop at Time 1, and five months after the workshop at Time 3. There was also some evidence of a reduction in Pawn Scale scores over time in Sample A. No such difference was shown for Contrast Sample C. In summary, these results point to workshop participation as a possible effect in reducing anxiety and helplessness in the Workshop Samples.
Table 15

Summary of Significant Results for Samples A, B, and C

<table>
<thead>
<tr>
<th>Scales</th>
<th>Significant effects</th>
<th>Between-samples difference</th>
<th>Sample</th>
<th>Within-sample difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognitive Anxiety (Sample/Time) and Time</td>
<td>Time 1 $p &lt; .001$</td>
<td>A</td>
<td>$p &lt; .01$</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>B</td>
<td>$p &lt; .01$</td>
<td></td>
</tr>
<tr>
<td>Pawn Time</td>
<td>Time 1 $p &lt; .03^a$</td>
<td>A</td>
<td>$p &lt; .03^a$</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>B</td>
<td>$p &lt; .01$</td>
<td></td>
</tr>
</tbody>
</table>

$^a$ Although result is not significance at $\alpha = .01$, it approaches significance.

The findings for the Cognitive Anxiety and Pawn Scale scores for Workshop Samples A (Above average), and B (Normal), and Sample C (Contrast), are illustrated in Figures 3 and 4 below.

![Figure 3](image)

*Figure 3. Mean Cognitive Anxiety Scale Scores for Samples A, B, and C at Times 1 and 3*
The results of these tests confirm those undertaken with Workshop Samples A (Above average), and B (Normal). The emotions associated with longer term change, that significantly distinguished the Workshop Samples from those of Sample C (Contrast), were those of anxiety and feelings of helplessness. The evidence thus only partially confirms the proposition stated in Hypothesis 3. There was a beneficial result for Sample A (Above average), in that there was a significant long term decrease in feelings of helplessness, and a long term decrease in anxiety that approached significance, but there was no significant long term change for positive measures. I shall comment on this aspect of the results in Section 8.9.6. As noted in Section 8.9.4.4, in a result I had not predicted, participation in the Workshop appeared to produce beneficial results for women in Sample B (Normal), whose initial distress was within normal levels. Their scores showed significant reductions in anxiety and feelings of helplessness, even five months after the Workshop. This change was not shown in the Contrast Sample.
8.9.6 Reflections on the Findings of Study 2

Women were allocated to Workshop Samples A (Above average), and B (Normal), on the basis of differing levels of distress, yet no other significant differences between those samples was shown in later analyses. Although the samples were closely matched, as described in Section 8.4.2, significant differences were found between the Contrast Sample, and the Workshop Samples, on measures of anxiety and helplessness. It appears that although the Workshop Samples differed in degree of distress, it was the women who were more uncertain, and felt a greater degree of helplessness, who volunteered for the workshops, resulting in the differences that were found between the Workshop Samples and the Contrast Sample.

The Cognitive Anxiety Scale, used in this Study as an indicator of the need for transition, was reduced by participation in the Workshops, regardless of women’s initial levels of distress. It appears the Workshops assisted women at a transitional time. In addition, participation in the Workshops reduced women’s feelings of helplessness, which I have argued would assist women to engage in the C-P-C Decision-Making Cycle.

Increases in feelings of control, hope, and positive emotions occurred in the short term, immediately after the Workshops, but were not sustained over five months. These feelings would indicate that women were satisfied with their meaning-making choices, and not experiencing any need for change. Women clearly felt less uncertain and helpless about their choices in relation to menopause, even five months after the brief workshops, which seem to have been sufficient to assist women to move from anxiety to engaging in decision-making. The women also showed short-term increases in feelings of control, hope, and positive feelings. As the menopausal transition is a state that continues for some time, however, a longer intervention may be more
appropriate to achieving longer-lasting satisfaction with decision-making, feelings of control, hope and positive feelings.

It is important to note that all the women in this study had high initial scores on the Origin and Positive Affect scales, possibly an effect of their predominantly high occupational status (Westbrook & Viney, 1980), as I noted in Section 8.9.3, in relation to Sample A (Above average). It may be that it would be unrealistic to expect the levels of these women’s scores to rise and remain higher than their initial levels. Alternatively, it may be unrealistic to assume that women can experience a feeling of control in their choices about menopause, when those choices are so frequently subject to public debate.

The Menopause Workshop did appear to achieve some significant results for the participating women. Other examples of the successful use of brief interventions have been reported in the personal construct literature (Ravenette, 1999; Viney, 1995; Harter, 1995). The significant results of this brief workshop are in some ways similar to the significant results found by Viney, Clark, Bunn and Teoh (1985) in their provision of brief crisis counselling for adults with illnesses. In that research, many patients had only one or two interactions with the counsellor, and few had more than four. The researchers comment that, “the unusually powerful effects of the counselling intervention can be attributed to its provision during a period of crisis for the patients … people in crisis are open to change” (p 63). Although menopause was not commonly experienced as a crisis by women in this study, it was clear that it meant a significant transition for some women. As Viney (1995) says: “transitions give people opportunities to revise their construing” (p 113). When women experience menopause as significant it may well present an opportunity for change similar to that experienced in crisis.
In an age of financial restrictions on health services (Neimeyer & Raskin, 2000), and increasingly ‘time-poor’ professionals, brief interventions are likely to become more important. This study offers evidence of a brief, and novel, application of a personal construct approach, which was helpful to women experiencing, or anticipating, transition, regardless of their levels of distress.

**Limitations**

The choice of design, while appropriate for this study, limits the ability to generalise from the findings. The outcomes must therefore be regarded as applicable only to other women with comparable characteristics. It is encouraging, however, that the workshop appeared to have a beneficial effect for women with normal levels of distress, as well as women with higher than normal levels of distress, which suggests that further research with more representative samples could be undertaken without undue risk. I further discuss the limitations of this study in Chapter 10.

In Chapter 9, I consider the processes of change that took place during and after the Menopause Workshops. After an introduction to some personal construct issues, I discuss the approach to experimentation that I took in relation to women’s confusion about menopause. I also present an outline of the advantages, and challenges, of working with groups in the workplace. I discuss the context for change offered by the workshops, and provide examples of the Diary Record Sheet (Part 2 of the Data Collection procedures), I used during the workshops. I follow this with a discussion of the pathways to change provided by the workshops, and provide a perspective on individual change. I then present four case studies to illustrate women’s construing throughout the course of the research. In the following sections, I discuss the findings from the Evaluation Sheet (Part 3a of the Data Collection procedures, and the women’s responses to the Report to Participants (Part 7 of the Data Collection procedures).
CHAPTER 9

PROCESSES OF CHANGE IN THE MENOPAUSE

WORKSHOPS
I considered personal construct theories of change in Chapter 3, following later, in Chapter 6, with an account of personal construct approaches to therapy and workshops, and, in Chapter 7, a full outline of the Menopause Workshops. In this Chapter, I now consider details of the processes of change that took place during and after the Menopause Workshops. After an introduction to some personal construct issues, in Section 9.2, I discuss the approach to experimentation that I took in relation to women’s confusion about menopause. In Section 9.3, I present an outline of the advantages, and challenges, of working with groups in the workplace. I then, in Section 9.4, consider some of the challenges of group-work, such as balancing individual and group needs. In Section 9.5, I discuss the context for change offered by the workshops, and follow this, in Section 9.6, with examples of my Diary Record Sheet (Part 2 of the data collection procedures outlined in Section 8.8.3). This is a record of my own construing during the workshops, a reflexive component to the data collection strategy (Banister, Burman, Parker, Taylor, & Tindall, 1994). That record is followed by a discussion, in Section 9.7, of the pathways to change, including the relationships, and cycles of construing, which I observed during the workshops. Section 9.8 presents a perspective on individual changes in cognitive anxiety scores, in which individual scores are considered in light of group data. In Section 9.9, I follow this with examples of individual construing, illustrating changes in construing over a five-month period. In Section 9.10, I present four case studies illustrating women’s construing from initial interview, to participation in the Menopause Workshops, and final follow-up data collection.

I then, in Section 9.11, present findings, and comments, from the Evaluation Sheets completed by the women who participated in the Workshops (a section of Part 3 of the data collection strategy). This is followed, in Section 9.12, by a report on Part 7
of the data collection strategy, in which women were advised of Study 2 findings, and asked for their comments.

Throughout this Chapter, I present, as illustration, direct quotations from women experiencing or anticipating menopause. These are drawn from the formal data collection procedures, and my Record Sheet observations and notes, supported by tape-recordings when available. I also use examples of drawings and other material, in cases where women gave me permission to use them. In order to protect women’s confidentiality, and preserve their anonymity, I not only used numbers to distinguish women during data collection procedures, but I then assigned pseudonyms to the identification numbers, using only names that were not held by any woman taking part in the research. It is these pseudonyms that I have used to distinguish women throughout this document.

9.1 Introduction to Some Personal Construct Issues

The personal construct therapist or researcher faces a challenge that is both more daunting, and more interesting, than that faced by colleagues working within frameworks of greater certainty. Being attentive to the multifaceted processes and cycles occurring within a group may challenge the range of convenience of the therapist’s construct system, and so result in anxiety, if not threat, depending on the earlier experiences of the therapist. On the other hand, there is a freedom implicit in the jettisoning of certainty. The relatively free approach of the personal construct researcher is underpinned by the support provided by established goals and strategies, such as the goals for group work outlined by Viney (1996) and the strategies for promoting therapeutic movement developed by Kelly and other clinicians (Kelly, 1955/1991a, 1955/1991b; Viney, 1996; Winter, 1992). The Menopause Workshop was planned, and facilitated, within the framework of freedom and support that a personal construct approach allows.
9.2 The Approach to Experimentation: Exploration of Confusion

The workshops were designed as a response to the women’s need for an opportunity to explore their feelings of confusion, and their inability to predict what was happening, which was identified in Study 1. The workshop activities were therefore focussed on the Creativity Cycle and the C-P-C Decision-Making Cycle, as appropriate mechanisms for experimentation and movement for these women experiencing transition. The workshop was designed to facilitate our achievement of therapeutic goals such as “making meanings … explicit, developing alternate stories … and changing patterns of action” (Viney, 1996, p 157).

Theoretically, this framework allowed responses to individual differences in the patterns of the women’s construing. For example, focussing on tightening or loosening of constructs during our group discussions. In addition, workshop planning was based on the notion that not all of the women’s constructs would be readily available for verbal examination, particularly because menopause encompasses so many somatic manifestations that might evoke nonverbal, or even preverbal, construing. The potential for preverbal expressions of construing was therefore built into the workshops, through inclusion of drawing, and enactment that was not necessarily verbal in the first instance. The strategy was a V-I-A (verbal-imaging-acting) pathway for movement, as I described in Chapter 7.

The approach was predicated on the premise that the “known group” would provide women with a safe context for experimentation. A context where generation of anxiety or other distressing emotions would be limited by mutual support (Winter, 1992), and where the extent of loosening in experimentation would be likely to be balanced by the tightening effects of working in a group (Neimeyer, 1988c).
9.3 Working with Existing Groups

9.3.1 Advantages

The strategy of working with self-selected groups, predominantly based on existing work groups, had major benefits. Women were able to take part in a group where membership had been negotiated, and agreed on, and where their decisions about disclosures, and sharing construing, were made in the context of familiarity with other members of the group. In terms of the dynamics of group formation, there was a saving in time, and therefore potentially cost, in working with existing work groups as it precluded the need for sessions devoted to the preliminary processes of group formation, such as the initiation of mutual support (Kelly, 1955/1991b). It facilitated, and accelerated, the process of shared construing, a major benefit of personal construct group work (Viney, 1996). It meant that group interactions were often characterised by an intensity, and a discussion of sensitive topics, that might otherwise have taken much longer to achieve. I shall provide examples of this in Section 9.7.

In addition, many women reported that participation in the Workshop Groups had strengthened their workplace groups and provided a workplace bond that was not present before. An example of this was given by Hazel, in her response at Time 3: “those few meetings actually brought some warmth and ‘humanity’ to my work experience at that time, which was a decidedly unhappy one.” I shall provide other examples in Section 9.7.4. There were, however, some challenges to working with workplace groups.

9.3.2 Challenges

9.3.2.1 The Impact of Workplace Hierarchies

Throughout this study all workplace groups were self-selected, as described above. When attempting interventions in the workplace, however, differences in status may affect the degree to which people feel free to fully participate in activities.
**Group 4**

Group 4 was a self-selected workplace group working for the head office of a large government department, located in Sydney city centre. The workshops took place in a meeting room, where we sat around a large table, but there was enough space in the room to form sub-groups when required. Although the women came from the same workplace, they worked at different levels in the workplace hierarchy. Staff came from both clerical and professional levels in the organisation, and therefore, to some extent, from separate sub-cultures. The bond between them, however, was that they were women approaching, or experiencing, the menopausal transition.

I felt that there might have been some reluctance, on the part of women of both occupational levels, to disclose very much in front of colleagues from a different level. In Session 1, in the first activity, some women gave very brief responses. As other women, however, started to explore their responses in greater depth, demonstrating the safety of experimentation, the women who had responded briefly returned to their previous responses, and elaborated them. The session finished with a greater feeling of group cohesion, and a light-hearted mood. At each session, however, I felt that the issue of the implicit workplace hierarchy remained a challenge.

**Application of Personal Construct Ideas**

In terms of personal construct theory, a diverse group should provide greater opportunities for developing more comprehensive construing (Kelly, 1955/1991b). In groups taking part in Study 1, this appeared to be the case. In Study 2, however, the greater degree of disclosure required may have inhibited interaction in the group discussed above, in which there were women at different levels in their organisation. In this case, in which the workplace had a strongly hierarchical culture, the duration of the workshop was probably not sufficient to elaborate organisational issues, and derive a greater benefit from the diversity within the groups. In Group 6, in which the
organisation had an explicitly egalitarian culture, there was no apparent effect from differences in the women’s occupational roles.

**Recommendations**

Depending on workplace culture, and the reason for the group’s existence, it may not be appropriate to mix staff from different occupational levels or sub-cultures. It may be necessary to explicitly address this during group formation, as a senior staff member may volunteer as a member of the group, and less senior staff will then feel that they are not in a position either to withdraw, or veto the inclusion.

Alternatively, if group members are comfortable with the composition of the group, but are likely to have difficulties with cohesiveness, an intervention with a greater number of sessions would provide greater opportunities for integrative activities.

**9.3.2.2 The Impact of Other Workplace Interactions**

**Group 1**

Group 1 was a self-selected workplace group, working at a government facility in an outer Sydney suburb. The workshops were held in a meeting room at the women’s workplace, where we sat around a table. As the women entered the room for Session 3, it was clear that at least one person, Wanda, was disturbed. The group took time to ascertain whether she was able to continue with the workshop. I was unsure about the cause of her emotion, and whether she would express distress or anger. It was difficult to reorient the group to workshop activities, and the time taken placed pressure on the timing of the workshop.

After the group Wanda and two other women asked for informal counselling in relation to the distressing issue. I was able to provide this. It appears that three members of the group had attended the session immediately after a workplace incident that had caused tension between Wanda and Xanthe. It was a measure of the success
of the group processes that they were able to put this aside whilst taking part. Indeed, feedback later revealed that the participation in the workshop seemed to have assisted the women in reforming as a viable work group.

Application of Personal Construct Ideas

In workplace-based interventions, it is clearly a possibility that construing, or emotion, associated with workplace issues might be carried into the intervention. At the time of Group 1, discussed above, I made a note that for all future groups I would try to encourage the women to discriminate between their workplace activities and feelings, and the activities of the workshops. I resolved to emphasise that the workshop would be time out from the workplace. It is, however, to some extent inevitable that construing, or emotion, associated with workplace issues will be present. Since the structures of the workshop were designed to promote understanding others, and mutual exploration of construing, they can be used, however, to facilitate richer relationships in the workplace.

Recommendation

Group facilitation should include structures to assist participants to distinguish, and bind to a specific context, the ongoing construing of relationships, and activities, of work groups. In a brief intervention, such as these workshops, a short discussion of this topic, to bring it to participants’ awareness, would be suitable, particularly as the overall structures of the workshop were designed to facilitate construing of others, as the women of Group 1 found.

9.3.2.3 Balancing Individual and Group Needs

This section deals with an issue that is not specific to working with existing groups, but is a challenge in group-work. Given the infinite variety of possible constructions of the individuals who form groups, a personal construct therapist must approach group-work with an anticipation that there will be a correspondingly infinite
variety of interactions within the group. A recognised challenge in working with
groups, however, is the difficulty in balancing individual and group needs.

In any group-work there will be difficulties at times in balancing individual and
group needs. Strategies for resolving such problems have been suggested in, for
example, Winter (1992), and Neimeyer (1988a). In this study, groups were
appropriately diverse. Menopause held a variety of meanings for women, ranging
from very distressing meanings, to more incidental meanings. Also, women’s
menopausal status ranged from premenopausal to immediately postmenopausal. The
groups were not as homogeneous as groups of women with, for example, a similar
diagnosis. It was not surprising that during the workshops, occasions arose when it
was challenging to meet the needs of individual women when one woman was
disclosing more significant issues than the others. This was particularly an issue
because there was only one facilitator.

*Group 2*

In Group 2, for example, two sub-groups were formed for an activity in Session
1. Intending to participate in both groups, I sat in one group in which a woman had
expressed ambivalence in the previous activity. Nancy shared a concern about a loss,
which was clearly of great importance to her. She described herself as being “caught
in a land between hope and despair.” The group took their cues from this to engage in
a discussion of their losses, and I felt I should not leave this process to move to the
second sub-group.

When the two groups reconvened, it became clear that the second sub-group
had had difficulty with the task and treated it fairly facetiously. I realised that it may
have been my presence in the first group that had provided a context for such an
intense discussion. It was clear that it had not been helpful to be occupied with
attending to only one sub-group. I had found it difficult to balance my response to
Nancy’s obvious expression of anxiety, or even threat, with my response to the group as a whole, and my responsibility to maintain the session schedule. Not only did I feel that I had not assisted the second sub-group to explore their construing, I was also left with the feeling that I had not been able to facilitate an adequate response to the Nancy’s needs. After the Session, I dealt with my own distress by contacting Nancy to acknowledge her sharing of a significant concern, and to offer a wider context for the issue. She wrote back by email, saying that she appreciated the “acknowledgment of her contribution.” An analysis of the content analysis scale scores revealed that Nancy’s anxiety had reduced considerably after the workshop, as I shall discuss in Section 9.9.

At the time of the workshop, I noted that the balancing of individual and group needs was a dilemma for which I needed to develop strategies, as it might well happen repeatedly.

*Application of Personal Construct Ideas*

After this experience, I tended not to join sub-groups. I remained alert to whatever was happening while recording my own reactions to processes. So as not to distance myself or take up a role outside the processes, I emphasised that whatever group members were working on was for those women only, and that they could choose what to share with the rest of us in the following discussion. The presence of the facilitator in a small group alters the interactions between group members, and in an intervention based on the notion of exploration, rather than learning, may be problematic. Where uneven numbers required my participation, however, for example in pairwork, I joined in, as a woman with concerns similar to those of other women.

*Recommendation*

The workshop facilitator should, where possible, promote the autonomy of group members in the activities of the intervention, by refraining from automatic
participation in sub-group work, unless it is possible to work with two facilitators, when responsibility for participation in small groups may be shared between the two.

9.4 The Context for Change: Sessions 1-3

A personal construct approach provides a hopeful orientation (Viney, 1995), based on the possibility of change (Salmon, 1970), in which individuals are seen as “active and resourceful participants in their own experiencing patterns” (Mahoney, 2000, p 58).

It is unlikely, however, as Viney (1995) says, that people will develop new constructs if they have no opportunity to test the predictive value of their problematic constructs. Engagement in the Creativity Cycle, by the recurring processes of loosening and tightening constructs, is central to the development of new construing (Viney, 1995), as are opportunities for testing constructs, and the validation and invalidation of construing. Particularly at times of transition, such as menopause, people may alter in their view of themselves and their worlds (Viney, 1992). Whilst transitions may give people opportunities to revise their construing, they may experience difficulties if there is no suitable context for revision (Viney, 1995). The first pathway for change, then, is a context for revision of construing.

The Menopause Workshop provided a context designed to encourage exploration and creativity, and to stimulate development in women’s construing about menopause. Each session was built around a central creative activity, a “novel situation” (Kelly, 1955/1991b, p 1130), which provided a “framework of anticipation” (p 1125) for the women involved. These activities were the basis for “controlled elaboration” (p 589), to extend the range of convenience of constructs, and help the women to use these constructs in dealing with new experience (Kelly, 1955/1991a).

The central activity in Session 1 was a self-characterisation (Kelly, 1955/1991a), followed by a discussion of the women’s strengths. The writing was
planned as a private activity. A self-characterisation written to be seen by others would be very different than if it were written for oneself. At the end of each session, I asked women if there was anything they had produced that they were willing to share with me. In the event, the self-characterisation was the most private of all activities in the workshop. Four women, out of 38, shared their writing with me. Women had no trouble, however, in compiling a group list of strengths based on individual self-characterisations, and this was recorded for the groups.

Although I emphasised the self-characterisation should be written sympathetically, one woman, in each of two groups, responded that she could only think of negative qualities. In response to this, the women in Group 3 encouraged Michelle, the woman in question, and each other, to write positively. In Group 2, we were able to assist Nina in reconstruing (to her satisfaction) a perceived negative quality “indecisiveness” in terms of a more valued quality “creativity.”

At the end of Session 1, many women reported that they had found the processes of writing about themselves very rewarding. The women in Group 2, for example, said that writing had helped them to clarify issues with which they were dealing. Section 9.6 reports the details of women’s evaluations of the workshop.

In Session 2, the central activity was drawing, based on Ravenette’s (1999) technique. The women often showed initial reluctance, close to refusal, to engage in drawing. Pat, in Group 2, put her pen down when the drawing activity was introduced, and said “I do not feel comfortable drawing.” We arrived at an elaborated understanding of the task, and Pat agreed to take part. In reviewing original expectations at the end of the Session, the women referred to their initial reluctance to undertake the drawing exercise, and their subsequent involvement and interest in the process. I then asked “I wonder who tells us we can’t draw?” In response to my question Pat and Nancy immediately volunteered stories of having been explicitly told
that they could not draw, one at age 10, and one at age 13. One of the stories clearly
still had power to distress. We briefly explored this, and the feelings seemed to be
contained. All the participants had my contact details, and knew they could contact me
if they needed to follow up further in an individual therapeutic situation.

In contrast to our writing activity, many more women volunteered to share their
drawings at the end of the Session. It was as though having overcome initial
reluctance to draw, the women then lost some inhibitions about expressing themselves
in this way. Fifteen women gave me permission to use their drawings.

The central activity for Session 3 was an enactment, to provide the women with
a novel means of construing alternative choices. It was designed in accordance with
Kelly’s (1955/1991b) maxim that “an experiment is a venture for which alternative
outcomes are conceptualised” (p 1125). Kelly pointed out: “much of the enactment
takes place on a nonverbal basis … feeling that … he is perceived as being in a certain
part, is, in itself, a form of adventure” (p 1147). Bearing this in mind, all forms of
enactment were encouraged, even if the response was a very brief nonverbal portrayal
of how a different situation would feel. Many women were uncomfortable with the
idea of this activity at first, but we discussed the acceptability of all forms of
exploration. Responses to this activity varied. Some women, such as Jenny, who
acted a role as a woman with physical difficulties, or Imogen, who acted a role as a
grandmother, were confidently able to roleplay. Other women’s participation took the
form of exploring the construing of the “other woman” by sketching a character, rather
than overtly “acting” her. Given the very brief nature of the workshop, I judged it
important to encourage all movement towards exploration, given that was the aim of
this activity. In the limited time available, it would not have been productive to focus
on the mechanics of roleplay, to the detriment of encouraging movement.
9.5 A Reflexive Record of the Workshops

A basic tenet of the personal construct researcher is that research is based on what Viney has called a “mutual orientation model” (Viney, 1987). It is based on an acceptance of researchers as construing people, with the capacity to know, and reflect on their own knowledge. It is crucial to this approach that both co-researcher and researcher are free to express doubts and make mistakes. Personal construct researchers have developed methods to reflect on their own experience, and practice, during interventions (Viney, 1996). For example, Winter (1992) cites Dalton,(1983), and Winter and Trippett, (1977), who used repertory grids to study the processes of therapist and client construing in psychotherapy groups.

I developed a Diary Record Sheet to describe, in a reflexive process (Banister et al., 1994), my own construing during the workshops. A similar technique was used by Lovenfosse (1999) with groups of mothers of children with “special needs.” In order to establish a safe context for exploration, I assured the women participating in the workshops that discussions in pairs or small groups were private, and limited to those concerned. The women were then able to exercise control over the amount of disclosure they shared with the wider group. I planned to join a pair or small group only if it seemed useful for some reason. After Group 2, I limited this direct participation further, as I have discussed.

Whenever possible, therefore, when my direct participation was not required, as activities progressed I recorded my construing on my Diary Record Sheet. In addition, after the sessions, I supplemented this account with fuller notes. I also recorded sessions on audiotape. This was only useful in some cases, as the workshop consisted of a great deal of pairwork and small group work, which resulted in undifferentiated sound on the recording.
An example of the Diary Record Sheet for Group 2 follows. It describes Session 2, when a drawing activity, took place. The workshop structures described in the Workshop Outline (Appendix I), appear in the left-hand column. My record and construing of the structures and processes, and my record of participants’ responses, are recorded parallel to the workshop tasks in the adjacent columns.

Table 16

*Example of Diary Record Sheet 1: Group 2*

<table>
<thead>
<tr>
<th>Structures</th>
<th>Researcher’s construing</th>
<th>Researcher’s record of the women’s responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Draw a situation and its opposite focussing on a choice you are facing/ or that you have made in relation to menopause.</td>
<td>Based on my experiences of earlier groups, I asked each woman to outline her choice before drawing to ensure that a real choice was being considered. Explained that drawing as such was not the issue, discussed feelings. Arrived at elaborated understanding of task and woman agreed to take part.</td>
<td>Some anxiety about this task.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>One woman said “I do not feel comfortable drawing” and put her pen down on the table.</td>
</tr>
<tr>
<td>1  Women discuss meanings in triads where women in turn take the roles of storyteller, listener and notetaker. 2  Share broad meanings with larger group.</td>
<td>I found this very successful. After initial reluctance women engaged in the task enthusiastically and were able to make useful connections for themselves based on their drawings.</td>
<td>Women were surprised at the depth of meaning in their drawings and seemed to enjoy elaborating their choice using their drawings as prompts.</td>
</tr>
</tbody>
</table>
This record of the workshops was invaluable, particularly because the audiotapes were not very useful. I could quickly jot down a key phrase or event, such as “I do not feel comfortable drawing,” and “put pen down on table.” I was then able to use these key phrases to write up my notes after each workshop session. The method allowed me to note any insights so that they were not lost in the very intense experience of facilitating the workshops. It also gave me a basis for revising my construing as I proceeded, as I could note changes that I wanted to make in the structures of the workshop in following sessions. For example, later in the session shown in the example above, I became anxious about the women’s responses.

Table 17

*Example of Diary Record Sheet 2: Group 2*

<table>
<thead>
<tr>
<th>Structures</th>
<th>Researcher’s construing</th>
<th>Researcher’s record of the women’s responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Pairs discuss:</td>
<td>Difficult topic. Possibly reluctant to admit not getting the support needed from close family. Perhaps because this is a work group. One woman seemed anxious to discuss the issue but was very careful not to be specific. Emotion: anxious about whether topic was suitable for the group but reassured by women’s willingness to discuss issue when we focussed on (e).</td>
<td>Some women showed some reticence talking about gaining support.</td>
</tr>
<tr>
<td>a) Who supports me in my choice?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b) Who doesn’t support me?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c) Who do I want to support me in my choice?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d) Is there anything I would like to change about my choice?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>e) What can I do to change the situation?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The Record Sheet allowed me to record my concern that the women in that group experienced difficulties in discussing sources of support with work colleagues. I anticipated that this might be because some women were reluctant to disclose details of their personal relationships in the workplace, and that this area was too close to core construing to deal with in such a brief intervention. As a result of reconstruing my approach to this important topic of dependencies, I changed my emphasis in the following workshops. I asked questions about how to gain additional sources of support, or how to improve avenues of support, so that women did not feel they had to volunteer details of current sources of, or lack of, support.

9.6 Pathways to Change: Relationships and reconstrual

This section contains examples, based on my diary records, in which the relationships within the groups seemed to aid reconstrual. The case studies provide illustrations of the ways in which group members were able to assist each other towards movement in construing. That is, in Kelly’s (1955/1991a) terms, they assisted each other in interpretation, increasing the permeability and range of convenience of constructs, and elaboration. Catina and colleagues (Catina, Tshuschke, & Winter, 1989) have found that invalidation prompts reconstrual only if there is an overall climate of validation in the group. It is clear from the examples that this was often the case, and women were able to assist each other in developing better discrimination, understanding others, validating constructs, and dispersing dependency (Viney, 1996).

Group 3

In Group 3, women were consistently supportive of each other and this led to a number of disclosures over the course of the workshop. I participated in the discussions to only a minor extent, to maintain focus. It was noticeable that the validation and interpretation of women’s stories were spontaneously undertaken by other group members. Women elaborated their choices in a lively, good-humoured
way showing great support for each other. This led to some women’s exploring their choices further still.

Nora shared a moving story about the background to her construing about menopause, which involved cultural practices about women’s bodies. I shall explore this further in Section 9.8. This story prompted a powerful discussion, in which Nora’s experiences were validated and explored by the group.

This context seemed to encourage a more reticent member of the group, Michelle, from a similar cultural background, to share more of her construing. After the workshop, some group members reported that a particular benefit from that session was that they now understood Michelle better, and that they realised that she had been somewhat isolated previously. The workshop had helped them to integrate her more fully into the work team. She reported a similar beneficial outcome, and also commented on her more positive feelings “I felt more comfortable about menopause after participation in the research. It seems less fearsome.”

This group was outstanding in the degree of support, empathy, and good-humour shown between participants. Exploration and elaboration were encouraged, experience was validated and reconstrued, and participants shared an experience that they found valuable for group formation in the workplace. These women no longer work together, because of workplace changes, but have met since the workshop, and are keen to meet again.

*Application of Personal Construct Ideas*

At the end of the workshop, these women said that they thought the workshop had been very successful, and I asked them why they felt this had been so. They said that it was because they knew each other well. This was interesting, because, as noted above, one woman, Michelle, was not actually well known to the others. During the workshop, it appears that the women in the group were able to “construe the
construction processes of another” (Kelly, 1955/1991a). They expanded their role relationships to include Michelle in their social processes, so that by the end of the workshop the other women felt they knew her well. Interestingly, the drawings from this group reflect a confidence in construing contrasting predictions, as the following examples demonstrate. Yolande’s drawing, shown in Figure 5, is a map that clearly illustrates some bipolar constructs, such as “closed mind” as an alternative to “insight,” “calm” as an alternative to “bored,” “creative” contrasted to “agro,” and “happy” to “sad.”

*Figure 5. Yolande’s drawing*
Figure 6 shows Hazel’s drawing, which contrasts two possible Hazels. One is a woman who is overweight, with symbols of a sedentary lifestyle, a cake and a bed. The other woman is slimmer, radiant with health, and surrounded by symbols of the healthy and satisfying lifestyle such as fruit, and sailing boats.

*Figure 6. Hazel’s drawing*

**Group 6**

Group 6 provided an example of a cohesive group in which group members played different roles in their organisation, but where the egalitarian ethos of the workplace appeared to offset possible differences in status and education. In addition, it was clear that group members appreciated the fact that they worked in a women-only environment, and experiences such as menopause were therefore more easily discussed
in the workplace. One woman said after the workshop: “working in a woman only environment has also assisted with my acceptance and understanding of this situation.”

Group members were mutually supportive throughout the workshop, and humour was often used. The following drawing, produced by Violet in the drawing activity in Session 2, was a somewhat humorous prompt for a more serious discussion about menopausal decisions. The drawing is also an illustration of the individuality of construing, and the importance of attending to an individual’s meanings. At first glance, the drawing seems as if it might encapsulate a very serious meaning of death, but when Violet explained her meanings, she presented them in an ironic fashion. The drawing portrays a farewell to existing teeth and the capacity to eat apples. In contrast to this, Violet shows a sunny future, in which she predicted a more confident future with her new teeth.

![Figure 7. Violet’s drawing](image-url)

Violet may well have been using her teeth as a metaphor for other significant changes in her life, and the humorous start to the discussion of options provided a safe
setting for more serious decisions. For example, Trudy’s drawing, shown in Figure 8, depicts Trudy construing the possibility of making a choice to leave home. The drawing shows the moment of departure as the most significant aspect of her current construing. Trudy shows herself caught at the moment of choice, between house and gate: she had not yet elaborated the choices after leaving.

![Trudy’s drawing](image)

Figure 8. Trudy’s drawing

The women in Group 6 reported that they found the experience valuable. This was reflected in postintervention feedback, such as “It … helped me to understand where my colleagues are at present,” “humour plays a great part in the show [sic] and I am lucky to work with a great bunch of women.”

Application of Personal Construct Ideas

For these women, the workshop clearly provided a safe context for experimentation, in which women felt able to reveal their construing about serious decisions. I believe that the women anticipated the commonality, and sociality, of construing between them, and were confident in their predictions that each could
construe the construction processes of the others. It was an example of the potential advantage of offering a workshop with an existing group of women.

*Group 4*

In Group 4, there was a striking example of the way in which participation in a group can help interpretations. In Session 1, there was an activity in which women had to think of a situation they had experienced that had some similarities to the one they were facing now, and then apply the insights gained from it. This produced a creative response, and seemed to help pre-menopausal participants, in particular, to reconstrue menopausal meanings. Kerry used her experience of working in another country, where the language and customs were unfamiliar, to elaborate the way she might approach menopause. This seemed to resonate with many other women, and inspired them to elaborate their own experiences, and share deeply held feelings with the group.

At the end of the session, Imogen used this metaphor to create a summary of everyone’s experiences of anxiety in relation to menopause, creating a binding thread of narrative for all the women’s contributions (Neimeyer, 2000). Imogen explained that they were all facing situations in which they did not know the language, the way to behave, or how to predict what would happen. She suggested that they could approach it in the way they would approach travel to another country, finding out about the customs, and learning some of the language.

*Application of Personal Construct Ideas*

This example was an instance of the greater richness of construing that potentially results from group work. In this case, the somewhat preemptive construing of premenopausal women was revised to provide them with a greater capacity for anticipating menopause.
Because individual meanings of menopause may relate to loss of some aspect of a woman’s role, such as youthfulness, perceived femininity, or fitness, discussions about menopause frequently evoke feelings about loss. Nina, one of whose choices was to avoid dealing with menopause at this time, mentioned that her mother had died when she was a child, and that she had known very little about it. Pat then also revealed that her mother had died when she was a child, and that her experience was similar.

When the two women revealed this crucial event in their lives, the group displayed great empathy and sympathy. I made a decision to facilitate the closure of the topic only when the women indicated that it was appropriate. The discussion was terminated after some time by Nina, the woman who had first raised the topic, who said “that’s a long time ago now.” It was a measure of the trust generated in the group that these two women had felt comfortable in discussing their feelings about such a sensitive issue. It was also interesting that Nina was able to bring the discussion to a close by time-binding the loss, and that the group assisted these women to discriminate between the feelings of loss at menopause, and the earlier experience of loss.

In this group, the women also said that they thought that participating in the workshop was particularly valuable in promoting closer relationships with each other in the workplace. Pat commented that she was “surprised how enjoyable I found that very personal sharing … I found it quite special.” She continued “it feels so comfortable to be able to talk about menopause with colleagues in the workplace. I was always afraid that you don’t talk about it because you don’t want to appear weak in any way, in a very competitive environment… so it’s great.” Paula observed that “it is good to be able to have the opportunity to relate to these problems with a colleague, which would not normally be the case if we did not have this workshop.” Paula also
referred to a process of reconstrual, saying “The menopause workshop was a wonderful experience where I was able to obtain insight into the concerns and issues people are facing with menopause.” Grace said that she had been anxious before attending because she had previously been embarrassed to mention her choices in other contexts. She now felt able to discuss the issues. After the session Pat came up to me and said: “you know we do a lot of work thinking and reflecting between the sessions.” Nancy commented that she had reflected on decision-making and menopause after Session 2. These comments were a encouraging confirmation of the power of the processes that had been taking place.

Application of Personal Construct Ideas

Viney has argued that people may go back to earlier sources of loss at difficult times (1995). It seems that the women’s construing of menopause in terms of loss had become linked to their earlier feelings of confusion and loss after the death of their mothers. In a group, feelings of loss can be validated and reinterpreted in a more productive way. These women were able to confirm each other’s experiences of being isolated from the processes of their mothers’ deaths, to discuss the lasting impact this had had on them, and to reflect on what it meant in the present context. The group was able to assist these women to discriminate between the feelings of loss at menopause, and the earlier experience of loss.

9.7 Changes in Construing

9.7.1 Changes in Cognitive Anxiety Scores

From a personal construct perspective, the acceptance of the individuality of construing is a framework for the observation of groups, and information about individual change can enrich discussions of the meaning of change within, or between, groups. In Chapter 8, I presented results that showed that Cognitive Anxiety Scale scores were (a) a significant measure of change for women who took part in the
Menopause Workshop, and (b) a measure that distinguished, at a significant level, between the workshop women and the women in the Contrast Sample. This was true for both workshop samples, that is, Sample A, in which the women had initial levels of distress above the normal range, and Sample B, in which the women had initial levels of distress within the normal range. To gain a more complete picture of the changes that took place among women who took part in the Menopause Workshop, I therefore examined individual scores measuring anxiety, in the samples of women with initial high and low distress. I used one standard deviation above or below the mean as a boundary for each sample, and identified scores that were outside the boundary at Time 1 and at Time 3. I recorded the score, the Identification Number (ID) of the woman, and the workshop group to which she belonged, so that patterns in the data could be identified.

Firstly, I identified scores in each sample that occurred over one standard deviation below the mean for the sample, that is, scores reflecting low initial levels of anxiety.
For the women who expressed less anxiety, the movement of individual scores within or below the range was not remarkable. It can be seen from Table 18 that only one women in each Sample had scores below the range at Time 1 and at Time 3. While four women’s scores moved within the range at Time 3, five women’s scores fell below the range by Time 3. More interesting is the fact that at Time 3 four of the 7 women below the range (in both Samples A and B) were members of Group 3 of the workshop. Group 3 is described in Section 9.6, and was notable for the fact that at the end of the workshop, the women said that they thought the workshop had been very successful. As also noted in Section 9.6, I found the degree of support, empathy, and good-humour shown between the women in the group outstanding. The low levels of anxiety in women’s scores five months after the workshop, appears to confirm both the perceptions of the participating women and my perceptions.
I then identified scores in each Sample that occurred over one standard deviation above the mean, that is, scores reflecting more anxiety.

Table 19

**Cognitive Anxiety Scale Scores Over One Standard Deviation Above Sample Mean**

*(more anxiety) at Times 1 and 3*

<table>
<thead>
<tr>
<th>Sample B</th>
<th>Sample A</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Score</strong></td>
<td><strong>ID/Group</strong></td>
</tr>
<tr>
<td>5.05</td>
<td>40/2</td>
</tr>
<tr>
<td>5.61</td>
<td>78/4^1</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1 Scores remaining over one Standard Deviation above Sample Mean
2 M = 3.52 SD = 1.33
3 M = 2.58 SD = .77
4 M = 3.67 SD = .89
5 M = 2.70 SD = .93

In the case of women who expressed more anxiety, in Sample A three women had scores above the range at both Time 1 and Time 3, whereas in Sample B, this was the case for only one woman. The other women with high scores at Time 1 had scores that had decreased to within the range at Time 3. Three women in Sample B, and one woman in Sample A, had scores that had increased above the range by Time 3.

At Time 1, three of the 7 women above the range were members of Workshop Group 4. Group 4 was discussed in Section 9.3.2.1. It may be that some of the tension I perceived in the group related to the interaction between members of the group with relatively higher levels of anxiety, and other members of the group with low levels of
anxiety. This interaction was beneficial for at least one of the women, as, in Group 4, at Time 3, the number of women with high levels of anxiety had reduced to two. As with Group 3, women’s scores in Group 4 provide some confirmation of my perceptions of the relationships within the Groups.

In Group 5, two women had scores above the one standard deviation range at Time 1 and Time 3. It must be noted, however, that one of these women, Roxanna, was from Afghanistan. At the time of her final response, war was in progress, and most of her family was still in Kabul or refugee camps, and she had not been able to contact any of them. It was clear that she was suffering from anxiety in relation to this, but nevertheless she indicated she was glad to hear from me and continue with the research.

Winter (1992) has found that individuals may benefit from specific forms of therapy, depending on their patterns of construing. If this is so, then it would be unusual if this particular form of intervention produced positive change for all participants. It is therefore encouraging that participation appeared to facilitate reduced levels of anxiety in the majority of women, regardless of whether they showed higher or lower levels of distress initially. It is important to note that in personal construct terms the experience of anxiety is not negative in itself. It is an indication of the need for change in the construct system. The fact that three women from Sample B had increased levels of anxiety at Time 3, as shown in Table 19, could therefore be an indication that those women had been prompted by the workshop to engage in new C-P-C Decision-Making Cycles.

9.7.2 Examples of Changes in Construing

Winter (1992) has reviewed personal construct studies dealing with reconstruing of the self, focusing primarily on studies that include the repertory grid technique. Findings from the studies included an increase in the elaboration of
construing of self and others after therapy. That result is consistent with the changes in construing of women in this study after the workshop. Not only did individual women elaborate their construing of themselves, but they frequently referred to increases in their understanding of their colleagues, illustrated, for example, in Hazel’s, and Pat’s, construing in this section.

In the context of his review, and based on evidence given by Adams-Webber (1989), Winter (1992) commented that “findings of increased identification with others can be considered to provide particularly impressive evidence of the effectiveness of the therapies concerned since self-other differentiation is one of the most stable of grid measures in people who are not receiving therapy” (p 157). Reconstruing may be revealed in client’s summaries of treatment sessions (Winter, 1992), but similarly it may be revealed in changes in construing over time. In this research, in which women responded to the same open-ended question three times over five months, it is possible to observe changes in construing developing over time. The following extracts illustrate the construing of women whose scores reflected a decrease in anxiety over five months. Hazel’s drawing of her choices, from Session 2 of the workshop, was shown as Figure 6, in Section 9.6.

Hazel

In the following example, Hazel, a premenopausal woman, shows a change in construing that reflects elaboration, as well as a reduction in anxiety.

1) “There isn’t really anything bad as such, just awareness of some sort of change.”

2) “It has very little meaning for me at present. I don’t believe I [sic] having any ‘menopausal’ symptoms.”

3) “The menopause group - I think that was really valuable for me. It provided a structured time to focus on an issue I had hardly thought about at all in
relation to myself. It was very valuable to be with my female colleagues in a
situation of intimacy and realize the similarities, differences and simply learn
from the experience of others. It’s a sadly neglected topic so thanks for
opening my eyes to it. I think there has been a shift in my view of menopause,
it’s now broader, and encompasses a broader sense of ageing or changing in
middle-age (and the consequent psychological changes) rather than viewing it
as a straight hormonal change.”

Hazel’s third response demonstrates that her process of elaboration had
continued after the workshop.

*Trudy*

Trudy was a menopausal woman whose construing also reflected a decrease in
anxiety over five months. In addition, Trudy’s construing showed greater elaboration
of construing about menopause after the workshop, and a consciousness of the choices
she was making. Trudy’s drawing of her choices, from Session 2 of the workshop, was
shown as Figure 8, in Section 9.6.

Time 1: “I think I first noticed that something was happening to me about two
years ago. The most significant ‘thing’ … was my memory. I have always
relied on my memory which has never let me down. Now I find it very
difficult to retain information and things seem to sift in and out of my memory
… Emotional issues have been evident, as in the being more sensitive, teary,
mood swings. I worry that my family will ‘disown’ me”.

Time 2: “Following the workshop I feel that I have a lot to reflect on and the
only way to do that is to take time out for yourself, look at options by gathering
information to help you decide which path you need to follow. Alternatively
you could speak to someone re sorting through information. Most importantly
I feel you owe it to yourself to be honest with yourself, so as to go on and have a fulfilling and worthwhile future”.

Time 3: “I feel like it is running along smoothly at present. I am trying to exercise on a regular basis … The hot flushes, ‘power surges’, are more frequent but not impacting on sleep at present. At the moment I am able to look at life more objectively and reflect on good times and all of my achievements. … I have made up my mind about the management of symptoms, and that is to keep an open mind.”

The previous examples illustrated the construing of women whose initial anxiety scores were within one standard deviation from the Mean, but showed a decrease in anxiety scores. The following example is of a woman whose levels of anxiety increased slightly from initial levels below one standard deviation from the mean at Time 1, to a level within that boundary at Time 3. Pat was a menopausal woman whose construing reflected a time of greater elaboration of her self-construing, and a greater confidence about her choices, even though that involved acknowledging the things in her life that were not so good.

Pat

Time 1: “The initial stages of menopause were traumatic for me – a lot of discomfort and frequently a feeling of ‘things female’ being out of control. I have read, talked to several doctors and swapped stories with friends. I have moved from being somewhat ‘shattered’ by the experience to acceptance. The main factor contributing to acceptance is that I am managing menopause and feel ‘in control’ again”.

Time 2: “The workshops really triggered a time of reflective thinking about myself, my life to date and about my future. I spend so much time in putting energy into work related and family related thinking that it was a luxury to
focus for a time on personal thinking within the structure that the workshops provided. … If the ‘journey’ to menopause is to get better for women then more information needs to be available, more openness amongst women and more medical support and understanding from doctors. … Your research … has already helped in building support links in our workplace”.

Time 3: “I think being menopausal is a motivator for me - I don’t want to have sagging muscles so I do weights, strengthening and conditioning exercises … I don’t want to have grey hair so I colour my hair … Life is not too bad! The choices seem so clear and I’m happy with my choice. … Thanks to your workshops, my work colleagues and I share more about how we feel, and support each other in managing how we cope. The bad (or not so good) things are: i) not been able to have a good sound sleep ii) how difficult it is to find a doctor with whom to establish a caring, continuing doctor patient relationship … iii) I cannot see as well as I used to … All in all, I’m well, happy and positive”.

In Section 9.8 I present further examples of changes in women’s construing, using four case studies to follow women from initial interview, through their participation in the workshop, to the final data collection five months after the workshop.

9.8 Case Studies: Four Women’s Experiences

In this section, I present four case studies to illustrate the uniqueness of women’s progress through the processes described in this document. The women’s backgrounds have similarities and differences. All of them were employed at a level categorised as “professional” by the Australian Standard Classification of Occupations (Australian Bureau of Statistics, 1998). In this classification system, professionals perform analytical, conceptual and creative tasks in the fields of, for example, health
and education, and have a bachelor degree or higher qualification (Australian Bureau of Statistics, 1998). The classification above this level is “manager,” and below it, is “associate professional” (Australian Bureau of Statistics, 1998).

Three of the women were employed in offices of a large government department located in various suburbs of Sydney. The fourth woman was a health professional in private practice in a rural area. The women’s ethnic and cultural backgrounds included Australian, Chinese-Australian, and European-Australian.

I have selected these case studies on the basis that these women’s changes in construing over time illustrate the findings for Study 2, presented in Chapter 8, both in terms of the changes in their content analysis scale scores, and in the themes identified in their meanings of menopause. In Chapter 5, I described the themes that were important to the women who were experiencing menopause. Olive’s construing exemplifies the four major themes identified in 70% or more of women’s responses in Study 1: physical or psychological symptoms of menopause; distressing feelings such as anxiety; feelings of confusion, and an inability to predict what would happen; an awareness of change and feelings of loss of control. She was concerned with uncertainty, lack of control and attempts to gain control, and medical issues.

The three other women’s construing reflects these, and other major and minor themes that were identified in between 30%-70% of women’s accounts of menopause in Study 1. Nora’s construing focuses on the themes of her mother’s experience, menopause as taboo, and cultural practices. Nancy’s construing reflects the themes of concern with menopause as a marker or significant time, childlessness (fertility), and mortality (death). Margo’s construing illustrates the themes of reconstruction and acceptance in her elaboration of her construct of “spiritual development.”

I provide examples of the women’s construing, firstly from initial interviews, then from responses to the open-ended question asked three times, firstly, before the
workshops, secondly, immediately after the workshops, and thirdly, at follow-up, five months after the workshops. In cases in which the women have given me permission to use additional material generated during the course of the workshops, I shall also illustrate women’s construing with drawings, or other responses to workshop activities. As I have done throughout this thesis, I have used pseudonyms to distinguish the women.

9.8.1 Olive

Olive was a woman of 50, from an Australian background. She was employed in a large government department located in a suburb of Sydney, Australia. At the time of interview, Olive had been experiencing menopausal changes for two years. At her interview she expressed a great deal of anxiety.

It means to me physical change, ageing, changes in my body, it is an uncertainty. … Entering into what I see as an age of uncertainty, and just not knowing. And because of my family history, with my sister with breast cancer, a fear … there is a degree of uncertainty, a degree of physical change.

Olive had attempted to improve her predictions and reduce her anxiety by seeking medical help, to no avail.

You go to the doctor to try and work out what is going on … and he says “well I don’t know if it is menopause,” or “you need to have these tests done.” The tests come back, and they are okay … So it is … that uncertainty, and apprehensiveness I suppose, and entering into an unknown. I think … you are entering another phase, yeah, that is what it means.

An important aspect of the changes for Olive was that she found that her symptoms invalidated her construing of herself as a person who gathered information in order to make accurate predictions.
I find I don’t know very much, and that worries me, because I’ve always felt that I’m on top of things from my own information point of view. And I’ve tried to be on this, I’ve actually tried to do some reading and alternate therapy … But I feel quite uncertain in terms of what’s in front of me.

Olive also found that the changes she was experiencing invalidated her construing in an even more powerful way; they invalidated her role as a mature and competent adult woman who can cope with anything.

I’ve never taken time off, or laid in bed or anything like that. But I must admit the last couple of times it’s been really traumatic in terms of the pain, and it’s just almost like being a teenager again and having really heavy periods … I’ve always considered myself to be really on top of all those sorts of things … it’s almost that superwoman type of thing … just sort of plough on.

Before taking part in the workshops, Olive’s response to the standard question was similarly distressed, and focussed on medical issues.

There would not be too much in relation to positives. I am currently having a number of medical examinations … at the moment in an attempt to find out why I feel so exhausted and tired. I have recently (five weeks ago) had a hysteroscopic [sic] examination and a D & C [dilation and curette] … I am still waiting for the specialist appointment to let me know what went on. The specialist disappeared soon after the procedure, and I had to ring his surgery to find out what went on, and what I should do from here. So overall the experience was really disappointing.

During Session 1 of the workshop, when asked to identify a strategy she had used in the past to resolve other distressing situations; Olive identified “control” as her strategy. She, together with another woman in her group, also placed “control,” followed by “meeting challenges competently,” at the top of a list of strengths and
strategies that they compiled. Olive was again referring to what appeared to be core construing about her role as competent, in control, and “superwoman.”

After taking part in the workshop, Olive’s response initially focussed on her distressing medical experiences. She had, however, taken action by consulting another medical specialist, and made a new choice about treatment. She had also experienced commonality with the other women in her group, and elaborated her construing to include other people in her constructions of menopausal behaviour. This may have partly validated her role as competent woman, as she had realised she was not an isolated “failure.”

Still absolute confusion as to how I feel about menopause, only I know that I am not alone in my confusion … Today I visited a specialist who has inserted a progesterone IUD, and I am keeping my fingers crossed.

Olive had also started to explore other sources of information. She was engaging in circumspection about her constructions of menopause, and progressing through a C-P-C Cycle to arrive at a preemptive construction of her needs. She was actively seeking control of her situation. Olive seemed to have been able to incorporate taking part in the workshop into her construing of herself as a “person in control,” and used her experience to elaborate and validate her role. The following passage provides some indication that she was able to expand the range of convenience of her construing about menopause, and reconstrue her experience, previously reflecting anxiety, as part of a spectrum of more predictable menopausal experience.

I have also visited the web sites … and have found these interesting so far.

Having attended the workshop I am more aware of the uniqueness of experiences that different individuals have, and have been more able to discuss the menopause with others. This has meant that I am NOT satisfied in putting
up with what to me is an intolerable problem - the issue of course is finding a solution to the situation.

At the five-month follow-up, Olive’s words reflected significantly less anxiety. The choice she had made to use hormone replacement therapy seemed to have given her some relief, and a greater sense of control. The conclusion to her response reflected an ability to construe the future in a more hopeful way.

My life with menopause has improved somewhat since I have been on my new progesterone IUD … I am not as tired but still cranky on a regular basis, which I am still trying to control. I am still feeling fat, and generally unhealthy, but am hoping I am getting through this menopause stage of my life - my friends who have gone through this assure me I am coming out the other end.

Table 20

*Content Analysis Scale Scores for Olive*

<table>
<thead>
<tr>
<th>Scale</th>
<th>Prior to Workshop</th>
<th>After Workshop</th>
<th>After 5 Months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognitive Anxiety</td>
<td>5.05</td>
<td>2.17</td>
<td>2.86</td>
</tr>
<tr>
<td>Pawn</td>
<td>2.64</td>
<td>1.50</td>
<td>1.32</td>
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<tr>
<td>Origin</td>
<td>1.52</td>
<td>2.29</td>
<td>1.78</td>
</tr>
<tr>
<td>Hope</td>
<td>-1.85</td>
<td>-.50</td>
<td>.49</td>
</tr>
<tr>
<td>Positive Affect</td>
<td>.68</td>
<td>1.32</td>
<td>.50</td>
</tr>
</tbody>
</table>

Prior to the workshop, Olive’s words reflected a level of cognitive anxiety slightly higher than one standard deviation from the Sample Mean. Olive’s scores, measured on the Content Analysis Scales after the workshop, illustrate her pattern of less anxious, more hopeful construing. After the workshop her score fell. At the five-
month follow-up, Olive’s Cognitive Anxiety Scale score was within the normal limits of one standard deviation from the Sample Mean. Her scores for the Pawn Scale also showed a continuous improvement over her three responses. Olive’s scores on the Origin Scale showed a rise after the workshop, which was not maintained after five months. Her scores for the Hope Scale, however, showed a continuous improvement over her three responses. Olive’s scores on the Positive Affect Scale showed a rise after the workshop, which was not maintained after five months. The continuous improvement in Olive’s Cognitive Anxiety, Pawn, and Hope Scale scores indicates that Olive was experimenting outside the group, and gaining validation for some of her new choices. She had not, however, arrived at a feeling of lasting control about her menopausal difficulties, and her scores for the Origin and Positive Affect Scales indicated this.

9.8.2 Nora

Nora was a woman of 49, from an Asian-Australian background, and had started to experience menopausal changes. She was employed in a large government department, located in an outer suburb of Sydney, Australia. At her initial interview, Nora was noticing distressing changes in her body, expressing anxiety about further changes that she anticipated. Construing herself as a menopausal woman appeared to be distressing for her. First she described some unpleasant changes, and her attempts to reconstrue the events.

I’m just in the middle of it I think. I didn’t even realise I was going through it, because about three months ago … I complained … that the air-conditioning was playing up. … I started to get very extreme hot flushes … You could feel it welling up from within. And it … seemed to me it lasted a long time, but in actual fact it was only minutes, and I’ve got a colleague … saying to me
“power surge, power surge.” And I say “yes, power surge” and people would then fan me, and I would fan myself.

Nora then described her construing about the implications of menopause, with meanings that were not positive for her.

I don’t think I was ready, and I don’t think I am still ready. So it’s become a bit of a bit of a non-acceptance. I don’t really want to be going through menopause, because I associated [it] with older women, and are [sic] not ready for being an older woman. … your figure does change, I have been battling with the middle age spread, and I’m not dealing with that very well. I’m not dealing very well with the hot flushes, with the increased weight.

Nora referred to an emotional upset she had just experienced. She did not elaborate on this; she chose to share the feelings not the event. Nora was not sure if the upset was having an impact on her symptoms, “whether because of my emotional state or not I … am unclear,” a further expression of anxiety. Nora had, however, taken some steps to try to extend the range of convenience of her construing about menopause, and to reduce her anxiety. She was experimenting with choices, but had not been able to satisfactorily reconstrue the menopausal process.

I’ve been to the doctors … and I’ve taken some Chinese herbs … I’ve taken some sage tea, which I am not very happy about, but it was my first cup today. Otherwise I’m trying to be as positive about it as possible, but it’s a bit yukky.

Nora revealed that she had had a traumatic experience when she was younger, and that was clearly part of her construing about menopause.

My mother was much older when she had children, and I can remember coming into the lounge room … and she was absolutely flooded with blood. And I thought “she is going to die,” and I couldn’t think … So there was myself and my younger sister, and we saw this, and we were absolutely shocked. We did
not know what was going on with my mother … And my mother just said “it’s all right, don’t worry, it just happens to women,” and I thought “oh I hope not.” That was … my sex education, so it was a frightening experience, my first experience with menopause.

Nora then revealed her discomfort in talking about menopause.

People don’t come and talk to you about menopause, in fact I am very reluctant to talk to people about my own experiences … I think it is a bit more of a taboo subject in our society … From my own Chinese background it’s not talked about at all, I don’t broach it with my mum … and with my mother-in-law, I don’t talk about it.

Prior to the workshop, Nora expressed considerable distress in her response to the standard question. As responses were written, she was able to indicate emphasis.

In one word HORRIBLE!!!!! I am moody and emotional. Feelings of inadequacy, hopelessness and alienation invade my thoughts often. I am experiencing constant hot flushes (about 5 in the day and 2-3 times at night sufficient to wake me up). After consulting the FPA [Family Planning Association] I started on [brand of hormone replacement therapy] which sent one side of my face numb. I thought I was having a stroke so have decided to do it without drugs. I’ve put on weight, about five kilograms, even though I don’t think I have increased my food intake. I certainly exercise regularly, playing competition squash twice weekly. My husband and children are unsupportive as they doesn’t [sic] understand and/or are uninterested in menopause. He is so busy lately that we haven’t the time to really communicate except for the normal daily messages. The good bits - there aren’t many!!! I now tell people what I’m going through hoping that by spreading the word, menopause won’t be such a “taboo” subject.
During Session 3 of the workshop, Nora was able to share the traumatic experience she had had as a teenager, which she had revealed in her interview. It is understandable that Nora’s construing about menopause showed anxiety, given some of the elements of her construing of this process. The story also illustrated why Nora might have difficulty in construing herself as menopausal, as her memory was that menopause was associated with a seemingly life-threatening condition.

I do remember when I was about 12 or 13 … my mother just absolutely bleeding, and I thought “my mother’s dying,” because I didn’t understand. … She nearly collapsed because of all this blood that was just coming out. And I started … to clean, and she said “no that’s my blood don’t touch it.” You know there’s a dilemma about women clean up after themselves, you don’t get your daughters particularly, I can’t remember whether I was menstruating or not. But anyway I wasn’t allowed to touch it, nobody was allowed to touch it, and in fact my mother said “go and lock the door,” and so she dealt with her own women’s issues, and it wasn’t until I started to read more, that I understood that that was what she was going through.

After Nora told her story, another woman found a way to link that past experience with the construing of the group, perhaps providing a context for Nora to reconstrue her mother’s actions. She reflected “perhaps people in those days, given the choices, would have made exactly the same choices that we are making; it’s just that they didn’t have the choice … so they just had to deal with it.”

Following the workshop, Nora repeated her themes of symptoms, concerns about her weight, and difficulty in construing herself as menopausal. After participating in the workshop, however, her distress was noticeably less, and her feelings of alienation seemed to have decreased. Sharing her construing with other
women seemed to have alleviated some of her anxiety, and she had made choices, and taken action in relation to her concerns.

Menopause partly dominates my life at present. I made the decision to take HRT … It has certainly helped my mood swings, and decreased the incidences of hot flushes. I’m still not very accepting of this stage in my life, so my self-image suffers. I am unhappy about my weight increase, and the resultant change in body shape. I have just rejoined the gym to try to address this issue … I enjoyed the opportunity … to listen to other people’s experiences and expectations. What I have learnt is that everyone is different, so there is no definitive answer about how to cope/manage menopause.

At the time of the five-month follow-up, Nora had been away on a holiday with her husband, and she had been taking hormone replacement therapy (HRT), which had settled her unpleasant symptoms. She had clearly been thinking about the processes of the workshop, and had gradually started to reconstrue herself in relation to menopause in the intervening months. Her response was much less distressed than before, and she had elaborated, and validated, her construing about bringing discussions of menopause into the open.

Being able to talk about menopause in our little group has helped. I even talked about it with some well-educated Asian women on our … cruise. They were uncomfortable, and initially were horrified that I would bring up such a “taboo” subject. Once we got into the conversation they didn’t want to stop, even when the men joined us. … Breaking down barriers is a slow process.
Table 21  

*Content Analysis Scale Scores for Nora*

<table>
<thead>
<tr>
<th>Scale</th>
<th>Prior to Workshop</th>
<th>After Workshop</th>
<th>After 5 Months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognitive Anxiety</td>
<td>4.12</td>
<td>3.31</td>
<td>1.71</td>
</tr>
<tr>
<td>Pawn</td>
<td>2.55</td>
<td>2.20</td>
<td>.52</td>
</tr>
<tr>
<td>Origin</td>
<td>1.47</td>
<td>1.99</td>
<td>.77</td>
</tr>
<tr>
<td>Hope</td>
<td>-1.18</td>
<td>-.85</td>
<td>3.12</td>
</tr>
<tr>
<td>Positive Affect</td>
<td>.56</td>
<td>1.15</td>
<td>1.55</td>
</tr>
</tbody>
</table>

Prior to the workshop, Nora’s words reflected a level of cognitive anxiety above, but within one standard deviation, from the Sample Mean. Nora’s scores measured on the Content Analysis Scales after the workshop, illustrate her pattern of less anxious, more positive construing. Her scores fell consistently across the three occasions that they were measured. By the time of the five-month follow-up, Nora’s Cognitive Anxiety Scale score fell just below one standard deviation below the Sample Mean. Her scores on the Pawn Scale also showed a continuous improvement over her three responses. Nora’s scores on the Origin Scale showed a rise after the workshop, with a slight reduction after five months, but her scores for the Hope and Positive Affect Scales showed a continuous improvement over her three responses. Overall, Nora’s scores showed a continuous improvement for all but the Origin Scale.

Nora’s choices to take hormone replacement therapy, and a holiday, had been validated. These decisions had improved her situation, however her construing also showed that participation in the workshop had facilitated a process of reconstruction for her. Nora showed that she had been engaged in a continuing process of
reconstruction since the workshop. She had carried her experiments outside the group, on her holiday, and from this account, she seems to have felt that her experiment was validated.

9.8.3 Nancy

Nancy was a woman of 49, from an Australian background, and she was experiencing menopausal changes. She was employed in a large government department located in a suburb of Sydney, Australia. At the time of the first interview she said she found it hard to answer the open-ended question “What does menopause mean to you?” and the issues she then raised were significant.

The first thing that came to my mind is that it is quite symbolic … because I do not have any children. So I think that menopause is quite a symbolic sort of thing, even though it is long before that that you become clear that you are not going to have kids. … the other thing is it is quite symbolic of ageing. … moving into that next group of women, and facing a different part of your life, the second half.

When Nancy responded to the standard open-ended question before the workshop, she again referred to the symbolic meaning that menopause had for her.

I’ve been fortunate to have good health and relatively easy periods for some years now. For this reason, ceasing bleeding has not been the huge relief which some friends report - it has been more of a non-issue. In symbolic terms, however, it is very important. I am a person who wished to have children, but have none. There’ve [sic] been many steps in the finalisation of this issue … and here is another step. This has not been emotional or traumatic, but it has been important in further defining my identity as a non-parent. I have a strong sense of moving into the future without a grown family … and I have few role models for this.
During the workshop in Session 1 Nancy described herself as “caught in a land between hope and despair,” as reported in Section 9.3.2.3. Nancy seemed to be elaborating and reconstruing these polarities as she took part in the workshop sessions. In Session 3, Nancy talked about how she had reflected on decision-making and menopause after Session 2, and said that, prompted by the sessions, she would now “play with the choices.” At this stage she seemed to have arrived at a more lighthearted construction of her choices. In her response to the standard question after the workshop she commented on her elaboration of the experience of menopause. Although she referred to mortality, she was able to reconstrue this in terms of actions, a contrast to her previous reference to “despair.”

Just being in a room with peers and colleagues, talking about the issue together, had a ‘normalising’ effect. Before that, I had not discussed the issue with regard to myself at all. … It made me very aware of my own prejudicial and devaluing attitudes - and my wish not to join the ‘older women’. It made me determined to ‘own’ the whole experience as important, and to make sure it was not to be hidden or avoided as a shameful thing. … I do experience … a strong consciousness of my own mortality - and the shortness of this one journey of consciousness that we make. The menopause is hugely symbolic for me of entering a ‘last phase’ of life … This somehow makes it time to get on with my own life - and to go for the experiences of life that I need. This often feels like selfishness or detachment. … Without the workshop I would not have found names for these thoughts and feelings [quotation marks in original].

By the time of the third data collection occasion, Nancy had clearly elaborated the polarities of her meanings of menopause, and reconstrued menopause as a less anxiety provoking and threatening experience. She retained her meaning of menopause as symbolic of another stage of life, and also her references to mortality,
made more vivid for her by the events of September 11, 2001. At this time, however, she was able to elaborate her construing of the future to encompass the idea that the universe might be playful, returning to her construction of “play,” which she had referred to during the workshop.

I remain far more interested in the psychological challenges of this transition, it’s so symbolic of moving into the second half of life’s bell curve. My identity is changing. … I am sympathetic to the physical pre-occupations of older women - previously so boring. I now understand that this chat about bodies recognises the intense reality that the body has its own clock … Bodies wear out - and let our spirits go. Not that death is dangerous or scary, but just that it is inevitable … (This week, too, we have seen the world trade centre come down, and have heard people taking their last breaths with resignation or terror.) These ‘intimations of mortality’ are enlarged by my knowledge that my tiny branch of the human family ends with me, I am the end of a six million year journey by my genes. … It almost feels as if my life is over already at this point where the child bearing aspect of my woman existence is completed and unused. My species no longer needs me - perhaps the rest is sheer play - or just a bonus due to the frivolity of the universe? … Your research helped me to be more open about my menopause, to be willing to speak about it occasionally when it comes up - and to move it from the intensely private to the slightly more public arena (quotation marks in original).

Nancy had clearly been engaged in a continuing process of reconstruction since the workshop. Despite her reference to the disturbing events of September 11, she seems to have been able to experiment with her construing outside the group, and arrive at a construction of menopause that was less of an ending, and that reflected more sense of future possibilities.
Table 22

*Content Analysis Scale Scores for Nancy*

<table>
<thead>
<tr>
<th>Scale</th>
<th>Prior to Workshop</th>
<th>After Workshop</th>
<th>After 5 Months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognitive Anxiety</td>
<td>3.83</td>
<td>2.82</td>
<td>1.95</td>
</tr>
<tr>
<td>Pawn</td>
<td>2.33</td>
<td>1.59</td>
<td>1.11</td>
</tr>
<tr>
<td>Origin</td>
<td>1.44</td>
<td>1.80</td>
<td>2.54</td>
</tr>
<tr>
<td>Hope</td>
<td>0.00</td>
<td>1.63</td>
<td>2.19</td>
</tr>
<tr>
<td>Positive Affect</td>
<td>1.12</td>
<td>1.15</td>
<td>0.25</td>
</tr>
</tbody>
</table>

Nancy’s scores illustrate her pattern of construing that was less anxious, less helpless, showing more feelings of control, and more hope. Her Positive Affect scores, however, fell, an indication of her concerns about mortality. Nancy’s clear improvement across five months, in all but one of the scales, indicates that she was experimenting outside the group, and gaining validation for her choices.

9.8.4 Margo

Margo was a woman of 45, from a European-Australian speaking background. She was employed as a health professional in private practice and at a women’s health centre. At her interview Margo expressed what seemed to be a bipolar view of menopause.

Menopause is a stage where I think it’s a transition … it’s the separation from one’s reproductive life to the life beyond … to do with spiritual development. And in a way it’s liberating, because I think you can free yourself from … that femininity about life, where you’re worried about your appearance, and … sexual appeal to other people. … there’s an element of fear because I’m
absolutely petrified about hot flushes and mood swings … because I get bad PMT and I get dismenorrhea … I hope I’m not an absolute bitch to live with when I’m in menopause.

Before Margo took part in the Menopause Workshop, she felt that she was experiencing some changes related to menopause. Her concerns reflected anxiety, but she also had positive constructions about her time of life.

I feel I am in the early stages, with some symptoms re mood, periods, skin, hair, aging issues. Good: midlife is a happy time for me re personal, professional, philosophical, financial issues. I feel “settled” and a level of contentment that I have not felt until now. I am comfortable with myself and less self critical. Bad: the body crumble - aches, pains, not being as fit as I was 10 years ago. Periods are annoying and the PMT stuff is tedious. Memory: it is hard to know whether my poor memory is sleep deprivation or early alzheimers or menopause.

Margo took part in Group 7, and during the workshop, she focussed on choices between earning more money, and a more rewarding, healthy life growing vegetables and riding a bicycle. These choices were reflected in a drawing that she made in Session 2.
After taking part in the workshop, Margo seemed to have found that her more positive construing was validated. In her next response she elaborated her anticipations with a sense that she would be able to achieve control in her decisions.

Menopause - so what! Life exists in so many ways, realities, stages, states and perceptions that menopause is yet another perception - artificially magnified by corporate interests with the view of brainwashing women to feel inferior yet again! I feel great, love life and look forward to the future! The bad is my body doesn’t match my thoughts and perceptions of what I want to do and the brief time in which I have to do it. The “pause” has more relevance than the “meno.”

After five months, Margo’s construing had continued to grow more positive. She had continued to elaborate the positive features of her time of life, and was
exploring strategies to do what she could to ensure that her positive anticipations would be validated. She was reconstruing her views about life in a thoughtful way.

Life is good in the perimenopause at age 47. I am not afflicted with the flushes or other symptoms yet. I believe I am more tolerant, relaxed and positive about life, and the world around me, despite the suffering of many souls. … Aging brings with it physical changes, but I think these are balanced by the philosophical growth and spiritual development that I pursue more these days. … Certainly exercise, good diet and a moderate lifestyle, with lots of sleep is essential to function optimally. … The more I think about it, the more I realise life is happening NOW and not to be postponed.

Table 23

*Content Analysis Scale Scores for Margo*

<table>
<thead>
<tr>
<th>Scale</th>
<th>Prior to Workshop</th>
<th>After Workshop</th>
<th>After 5 Months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognitive Anxiety</td>
<td>3.10</td>
<td>3.16</td>
<td>.94</td>
</tr>
<tr>
<td>Pawn</td>
<td>2.36</td>
<td>1.92</td>
<td>1.22</td>
</tr>
<tr>
<td>Origin</td>
<td>2.13</td>
<td>2.18</td>
<td>1.37</td>
</tr>
<tr>
<td>Hope</td>
<td>-1.89</td>
<td>-2.06</td>
<td>4.40</td>
</tr>
<tr>
<td>Positive Affect</td>
<td>1.59</td>
<td>1.92</td>
<td>1.44</td>
</tr>
</tbody>
</table>

Margo’s scores measured on the content analysis scales were interesting. Prior to the workshop, Margo’s words reflected a level of Cognitive Anxiety within one standard deviation from the Sample Mean. After the workshop her score was similar, but at the five-month follow-up, Margo’s Cognitive Anxiety Scale score had fallen below one standard deviation from the Sample Mean. Her scores for the Pawn Scale
showed a continuous improvement over her three responses. Margo’s scores on the Origin Scale showed a non-significant rise after the workshop, with a reduction after five months. Her scores on the Hope Scale, however, showed that she was less hopeful immediately after the workshop, but after five months her levels of hope had improved significantly. Margo’s scores on the Positive Affect Scale showed a non-significant rise after the workshop, with a reduction after five months.

In general, Margo’s scores illustrate the less anxious, more hopeful, pattern of her construing after the workshop. It is clear that she had been engaged in a continuing process of reconstruction since the workshop. Like other women, such as Nancy, she acknowledged that distressing events happen in the world, but she had developed an elaborated bipolar construction of menopause that seemed to be subsumed by a more superordinate construct of spiritual growth, allowing her an ultimately positive outlook.

### 9.8.5 Summary of the Case Studies

The case studies illustrate the types of changes in construing that the women experienced in Study 2. The findings of Study 2 were that, over five months, most women experienced a reduction in anxiety and feelings of helplessness, indicated by decreased Cognitive Anxiety and Pawn Scale scores. These women’s feelings of control, hope, and positive feelings, indicated by increases in Origin, Hope, and Positive Affect Scale scores, increased immediately after the workshop, but were not, in general, sustained over five months.

In Olive’s case, for example, her scores showed a continuous improvement on the Cognitive Anxiety and Pawn Scales, but the rise, after the workshop, of her scores on the Origin Scale was not maintained. Her scores showed an improvement for the Hope Scale, but the rise, after the workshop, of her scores on the Positive Affect Scale was not maintained. Nora’s scores showed a continuous improvement for all scales
other than the Origin Scale. Nancy’s scores indicated an improvement, over five
months, in all but the Positive Affect Scale. Margo’s pattern was similar to Olive’s.
Her scores on the Cognitive Anxiety and Pawn Scales showed an improvement over
her three responses. Her scores on the Origin Scale showed a rise after the workshop,
which was not sustained. Her scores on the Hope Scale, however, showed that after
five months her levels of hope had improved significantly. Her scores on the Positive
Affect Scale showed a rise after the workshop, with a reduction after five months.

These women’s words, and content analysis scale scores, showed that they had
been engaged in a continuing process of reconstruction during and after the workshop.
They were experimenting outside the group, and gaining validation for some of their
new choices. This is reflected by their decreased levels of anxiety and feelings of
helplessness. They had not, however, arrived at a feeling of lasting control and
satisfaction about their menopausal choices, and this was reflected in their scores for
the positive toned scales.

9.9 Participants’ Evaluation Sheets: Analysis of the Data

The women participating in the study were asked to complete Evaluation
Sheets after the workshops. As Yalom (1975/1995) commented, participant reports
can be a rich source of information. Twenty-nine women in the workshops (76%),
filled in the voluntary Evaluation Sheet (see Appendix N) given to women at the end
of Session 3. The reaction of 24% of women is therefore unknown (a table of
responses is presented in Appendix R). In summary, the responding women reported
that the workshop was helpful to them. The majority of respondents was in favour of
the workshop design as it was offered, although some women offered suggestions for
improvement: “would have liked now to reflect on drugs and issues in more depth i.e.
side effects.” This comment was coupled with a recommendation to extend the
workshop. The majority of the women were also in favour of retaining the number of
sessions as three, with some women referring to the other pressures in their lives: “three is good … but it is not an onerous commitment”; “about right with all the pressures.”

The women were asked to comment on the aspect of the workshops that was most helpful to them. Responses did not fall into a normal distribution, because all respondents indicated that the workshops had been helpful. The majority of women also indicated that all aspects of each session were helpful (Response Type 1).

There were two other types of responses: firstly, those in which the women nominated all aspects of an individual session as helpful (Response Type 2), and secondly, those in which women nominated particular activities as helpful (Response Type 3).

In Response Type 2, the greatest proportion of women (over 55%) nominated Session 1, in which a self-characterisation was the main activity. Perhaps this was because writing about, and discussing, themselves at that time of their lives felt more comfortable than participation in the drawing and enactment activities. Three issues are important here. Firstly, adults engage in drawing and acting less often than writing. Secondly, the activities were included to promote engagement in the Creativity, and Decision-making Cycles, and would thus be expected to engender a certain amount of anxiety. Thirdly, the drawing and enactment activities were future oriented, involving women in venturing predictions about their own choices, and their courses of action. These latter activities again would be expected to generate some anxiety.

Nevertheless, in Response Type 3, when women did make a distinction about what had been particularly helpful, they indicated aspects of the more challenging Sessions. After the enactment activity in Session 3, the final activity of in the workshops was sharing sources of support, and information, with the aim of dispersing
dependencies. Over 27% of these women nominated this as helpful. In Session 2, the discussion following the drawing activity was nominated as helpful by over 20% of these women.

Other comments indicate that some women found the drawing and enactment activities challenging, or unsatisfactory: “more difficult and less helpful”; “Session 2 was helpful but somewhere missed the point, became a narrow discussion”; but others did find them helpful “Interesting - but I did find Session 2 the most inspiring”; “excellent - most valuable.”

Additional comments about the workshops fall into three main categories: those indicating circumspection, and an engagement in the Creativity Cycle; those about sociality, or validation; and those about decision-making. Comments indicating an engagement in the Creativity Cycle included the following: “opened up a lot of areas and choices for me”; “after each session I reflected for some time on the things I said, the things that I raised as issues for me and how felt [sic] after the discussion”; “I thought the workshop was most helpful. It allowed you to explore issues that otherwise would never be considered”; “every part of this program added to my knowledge of menopause”; “it was a relaxing and stimulating time and has helped us discuss a very understated time of our lives.”

Some accounts of what was helpful reflected both an engagement in the Creativity Cycle, and sociality, or possibly validation: “you build up a rapport with group and feel free to talk about things you might not [otherwise]”; “the pairwork insights were good - getting different views”; “sharing with other women - best thing”; “sharing experiences”; “networking information among group”; “saw it wasn’t all negative”; “it was warm, informative and supportive.”

In other comments about what was helpful, decision-making was referred to by women who said: “I found the session very helpful in establishing where I am in my
problem solving process”; “made me much clearer… It really made me focus and feel [underlined in the original] the decision”; and in relation to the drawing activity, “hated the drawing [but] the discussion surrounding this was very helpful in clarifying and crystalising issues”; and “this was better than I expected, actually focussed [on my decision]” (words in brackets added for clarity).

The evaluation sheet was given to women after the completion of the workshop, and the postintervention data collection procedure. It is possible that women who did not find the workshops helpful chose not to complete the evaluation, however the excellent retention rate in the study, and the content of women’s responses at follow-up, do not support this argument. It seems most likely that the number of women completing the evaluation was affected by the pressures of the workplace, where the majority of workshops were delivered. In addition, the time pressures, already noted, that women experience in balancing their work and family lives, may have made it difficult for women to stay to complete the evaluation, where workshop sessions were held at the end of the working day. Some women may have been seen the evaluation as a dispensable part of the process.

9.10 Summary of Responses to the Report to Participants

A summary report of the data analysis was sent to all Study 2 participants. The women generally showed a very positive response. More than 55% of women responded to receiving the report. Over 45% percent of women responded with thanks, comments that it was interesting, or sent good wishes for the research. An additional 10% percent responded with further comments. Some comments were: “It reminded me of our group sessions and how much fun they were; a bright spot in what was then a rather bleak landscape. Also a chance to reflect, which is always precious. So I guess my experiences match up with the report’s findings”; “certainly very interesting - so now we have it officially confirmed, that talking to each other (in
positive ways) has an impact on our mental health … I hope you’ll be offering workshops again.”

Members of four of the seven workshop groups reported to me, by email, direct speech or on the telephone, that the experience of taking part in the workshop had strengthened their workplace, led to a stronger feeling of cohesiveness in that workplace, facilitated greater interpersonal understanding between these women, or provided the basis for on-going support for menopausal women in the workplace. Women noted that they felt that there were now other people in the workplace, with whom they could share their future menopausal experiences.

9.11 Reflections on the Processes of Change in Women Anticipating or Experiencing Menopause

The examples given in this Chapter illustrate the diversity and uniqueness of women’s meanings of menopause, which any discussion of menopause must take into account. Using a personal construct approach in the workshops gave the women, and me, a flexible and creative context for the cooperative exploration of individual meanings. Using a personal construct approach to group-work therefore gave us the benefit of a focus on individual meanings, together with the advantages of a shared exploration of menopause. Examples of cases, in which the sharing of meanings assisted women in reconstruing their experiences and anticipations, have been provided. A personal construct approach also provided us with an orientation to the future, that was crucial for a focus on reconstruction (Fransella & Dalton, 1990). It presented an opportunity to develop more flexible and creative construing in the future. The emphasis on discussion about choices, and gaining support for choices, allowed reciprocal elaboration of predictions and actions, with the aim of developing accurate predictions (Viney, 1996). In addition, a personal construct approach was the context for the provision of opportunities for loosening and tightening in relation to gaining
understanding and support, and opportunities for the dispersion of dependency. These processes are in direct contrast to many menopause interventions, which focus on education and information, as noted in Chapter 2, rather than on exploration, and creation, of individual meanings.

The significant results for this brief intervention are based on the flexibility, and individual orientation, of a personal construct approach. The Menopause Workshops appeared to have an overall beneficial effect for women who took part, regardless of their initial levels of distress. This effect was not shown in the non-intervention Contrast Sample, as I discussed in Chapter 8. In Study 1, many women clearly expressed a feeling of anxiety, and a need for an opportunity to explore their experience, and their decision-making related to menopause. Both the statistical results, and the content of their individual construing, appear to indicate that the Menopause Workshop provided that opportunity for the majority of women.

In Chapter 10, I review the findings of Studies 1 and 2. I discuss the limitations of the studies, and I also provide a perspective on the relationship between the quantitative and qualitative data in the studies. I evaluate the implications of the Study 2 findings for the Personal Construct Model of Menopause, and for the Menopause Workshop, and I also comment on the issues involved in working with women construing the menopausal transition. Finally, I indicate some directions for future research.
CHAPTER 10

WOMEN’S RESPONSES TO MENOPAUSE
In this final chapter, I reflect on the findings of Studies 1 and 2, and comment on the limitations of these studies. I also provide a perspective on the relationship between the quantitative and qualitative data in the studies. I then discuss the implications of the Study 2 findings for the Personal Construct Model of Menopause, and for the Menopause Workshop. I also comment on the issues involved in working with women construing the menopausal transition. Finally, I also show how the overriding objectives of this research were met, and indicate some directions for future research.

10.1 The Implications of the Findings of Studies 1 and 2

In this section, I reflect on the findings of Studies 1 and 2, and comment on the limitations of these studies.

10.1.1 Study 1

10.1.1.1 Reflections on Study 1

Menopause meant physical or psychological change for 87% of the women interviewed. For 74% of the women, the meaning of menopause involved distressing feelings such as anxiety. Seventy per cent of women reported feelings of confusion, an inability to predict what would happen in relation to menopause, an awareness of change, and feelings of loss of control over their bodies. In summary, 70%, or more, of the women were aware of change, and a need to reconstrue themselves, in relation to menopause. The need for changes to their construct systems had become pressing. These women were, however, attempting to continue with their normal lives whilst experiencing physical or psychological changes. They were also trying to appear controlled and professional at work, while suffering from these disruptive changes. In addition, many of the women saw menopausal status as linked to aging, but felt that aging workers were not welcomed in the workplace.
The meanings of menopause were strongly negative for the women in this study. The themes of awareness of change, particularly in their bodies, expressions of distressing emotion, and expressions of an inability to predict what was happening, were consistent throughout this sample of women, regardless of women’s menopausal status. The themes of a lack of opportunities for discussion, and difficulty in decision-making were also common. These strong themes, women’s evident distress, and the feedback from women who found the interview process beneficial, prompted the development of the Menopause Workshop, which was evaluated in Study 2.

10.1.1.2 Limitations of Study 1

Sampling

The choice of sampling methodology was based on the ethical assumption that participants in research should be volunteers. The sample was not randomly selected, but was a purposive sample directed to women experiencing menopause while in a workplace, or other non-domestic context. In the targeted organisations, women were invited to volunteer through staff networks. In the case of group interviews, the women were invited to guide decision-making on group formation and membership, to promote a research context for relationships of trust within a brief time. As a result of these factors, the findings can be generalised only to women with comparable characteristics to those interviewed. A larger study, with a more representative sample, would have been useful.

Data collection

The data collection method was by questionnaire for demographic and menopausal status data. The lack of definitions for menopausal status, however, limited the usefulness of the data collected for this variable. Future studies should provide women with formal definitions of menopausal status, before asking them to nominate their own status. This should reduce confusion, and would allow a more
accurate reading of the data in relation to different patterns of construing that might occur at different menopausal stages.

The data collection method for women’s meanings of menopause was interviews, which were recorded and transcribed, and then analysed for themes that were based on the personal construct model of menopause. The women’s own words were the primary source of data, “a source of well-grounded, rich descriptions” (Miles & Huberman, 1994). Boyatzis (1998) recommended four strategies for lessening the “contamination of projection” (p 13) by the researcher, in using thematic analysis. These were: developing an explicit code, establishing reliability, using several people to encode the information, and staying close to the raw information. In the case of Study 1, I developed an explicit code of themes, shown in Appendix G. I tested the reliability of the coding, by comparing my coding of themes with that of an independent rater, with a strong positive correlation between the two. I stayed close to the raw information, by using direct quotations from the women as examples of the themes, for coding purposes, and as illustrations of the themes in the description of the study. I was, however, the only person encoding the full set of data. The study, therefore, would have been strengthened by the use of one or more additional encoders.

10.1.2 Study 2

10.1.2.1 Design and methodology

The design of Study 2 involved provision of baseline data for contrast with postintervention data; the use of contrast samples; collection of comparison data after a period had elapsed postintervention; and reporting of the retention rate. In addition, this study developed a diagnostic screening assessment, in terms of the women’s distress, which provided data as to which women might benefit more from the Menopause Workshop. The evaluation strategy also included “personal narratives and
the qualities of human life that extend beyond the boundaries of diagnostic concerns and related symptom relief” (Fireman, 2002, p 219).

Concerns have been raised about situations in which the therapist and researcher roles overlap (Burlingame, Kircher, & Taylor, 1994). In such a case, Burlingame recommends reliability checks such as triangulation, with findings corroborated using two or more measures, or with two or more individuals. As a further check conclusions should be verified with study participants, to increase confidence in the reliability of results (Burlingame et al., 1994, p 60). In this study, in which I filled the roles of group leader and researcher, I used a variety of measures to evaluate findings. These included two content analysis scales assessing negative states, three content analysis scales assessing positive states, the women’s evaluations of the workshops, my own record of processes in the workshops, material produced by the women during the workshops, and the women’s responses to my summary of findings. In addition, I conducted rater reliability tests for the scoring of the content analysis scales.

10.1.2.2 Reflections on Study 2

The findings of Study 2 indicated a broad relationship between women’s participation in the workshops and improvements in their emotional states. The research predictions were only partially supported. Hypothesis 1 was supported, but Hypotheses 2 and 3 had more mixed results. Hypothesis 1 predicted that women’s constructions of menopause would reflect higher than normal levels of distress in a proportion of women greater than that expected in the general population.

Interestingly, as a sample, women who volunteered for the intervention had the highest percentage of higher than normal scores for distress. In total, 53% of women who took part in the intervention had levels of distress that were more than one standard deviation above the norm. This indicates that it was women who were
Hypothesis 2 predicted that, when women’s constructions of menopause reflect higher than normal levels of distress, they will also reflect higher than normal levels of anxiety, higher than normal levels of feelings of helplessness and lower than normal levels of feelings of control, together with lower than normal levels of hope and positive affect. This prediction was partially supported.

Women’s scores were analysed using the Gottschalk-Hoigaard Depression scale as a measure of distress. The occurrence of depression within or above the normal range was determined using norms set for the scale (Gottschalk & Bechtel, 1990). The women in Workshop Sample 2 were divided into two sub-samples on the basis of their levels of distress. Sample A (Above average) was composed of women whose scores were above the normal range; and Sample B (Normal) was composed of women whose scores were within the normal range.

The findings were that women with higher than normal levels of distress (Sample A) had, as predicted, higher than normal anxiety and feelings of helplessness, and lower than normal levels of hope. Results in regard to feelings of control and positive affect, however, did not confirm the hypothesis. I expected that the women with higher than normal levels of distress would have lower than normal feelings of control and positive feelings. In fact, this sample showed higher than normal feelings of control, and normal positive feelings. As noted in Chapter 8, this result may reflect the sampling in this study, as it has been found that higher levels of feelings of control, and positive feelings, are related to higher occupational status (Westbrook & Viney, 1980).

Clearly, the interrelationship between the emotions measured in these women is more complex than predicted. The feelings of anxiety, helplessness, and lower than
normal expressions of hope that were identified, were expressed as predicted. Feelings of control and positive feelings appear to have a more complex relationship to potentially distressing changes in life. It may be that these unexpected findings reflect these women’s beliefs, reinforced by higher occupational status and its attendant benefits, in an ability to exercise control to bring events to a satisfactory outcome in the longer term, and that these feelings were therefore independent of transitory events or states.

Hypothesis 3 predicted that if women’s levels of distress are higher than normal, when they have opportunities to reconstrue in relation to menopause, they are likely to experience a reduction in levels of anxiety, and levels of helplessness, and an increase in feelings of control, together with an increase in hope and positive affect. This hypothesis was tested in two parts. Firstly, Sample A, women with levels of distress that were higher than normal, was contrasted with Sample B, women with levels of distress that were within normal levels, to test whether any differences occurred between or within the samples before the Menopause Workshop, after the Workshop, and after five months. The findings for the women in Sample A were that there was a statistically significant long term decrease in anxiety, and a long-term decrease in feelings of helplessness that approached significance at $p = .26$. Although there was a significant short-term improvement in relation to the positive emotions, this was not sustained after five months.

In an unexpected result, the results for the women in Sample B showed a statistically significant long term decrease in anxiety, and feelings of helplessness. I had predicted that it would be women with higher levels of distress who would benefit more from the workshops. Despite the difference in levels of distress between Samples A (Above average) and B (Normal) there were no statistically significant main effects shown for sample on further statistical analyses.
The second set of tests contrasted Workshop Samples A and B with Sample C, the Contrast Sample. The results of these tests confirmed those undertaken with the Workshop Samples. The emotions associated with significant longer term change in the Workshop Samples, but not the Contrast Sample, were those of anxiety and feelings of helplessness. Scores for the Contrast Sample showed no significant difference over time, in contrast to the Workshop Samples.

In summary, the women’s anxiety, which was used as an indicator of transition in this study, was reduced by participation in the Workshops, regardless of the women’s initial levels of distress. In addition, this study proposed that a reduction in feelings of helplessness would assist women to engage in the Decision-Making Cycle. The women who participated in the workshops achieved this reduction in feelings of helplessness. Comments given on the Workshop Evaluation sheets indicate that some women were aware of an engagement in decision-making. These findings suggest that the women who participated in the workshops used the workshops to explore their construing, and begin the process of reconstrual, which reduced their anxiety, and allowed them to engage in decision-making. Bearing in mind Brown’s (2000) comment that: “greater care could be taken to devise interventions that are not themselves pathological” (p 305), it was encouraging that women taking part in the workshops improved in relation to their levels of anxiety and helplessness, regardless of their initial levels of distress.

Mackenzie (1994) commented that: “the verbal content analysis approach yields an independent view of the group climate … in contrast to the more common method of measuring group climate through member self-report instruments” (p 247). In this study content analysis scales proved successful in diagnosing, predicting, and assessing psychological states within a personal construct framework, providing a non-intrusive means of quantifying the personal meanings of participants.
Although it was encouraging that participation in the Workshops reduced women’s uncertainty and feelings of helplessness, the aim of increasing women’s feelings of control and positive feelings was not met in the longer term. I had argued that these feelings would indicate that women were satisfied with their meaning-making choices, and not experiencing any need for change. Significant, or close to significant, rises in positive emotions, occurred in the short term, immediately after the Workshops, but were not sustained over five months, indicating that the women’s satisfaction with their choices was not maintained.

There are two factors that should be considered in relation to this finding. The first factor is the issue of stability and specificity in measuring control. The authors of the Pawn and Origin Scales note that “Pawn perception, as measured by the scale, is a more stable characteristic than origin perception” (Westbrook & Viney, 1980, p 172). Given this, it is interesting that Pawn Scale scores were more responsive than Origin Scale scores to the effects of the workshop, an indication of the significance of the effect. Westbrook & Viney (Westbrook & Viney, 1980, p 173) also comment, however, that both “scales appear to tap changing patterns of causal perception” (p 173). In this study, there was a consistent lack of significant long-term improvement across the scales measuring positive states. It is possible, given the findings of Westbrook & Viney (1980), that the positive states are more context specific than the states of uncertainty and helplessness, and long term assessment of feelings of control may be complicated by less stable patterns of perception.

In a study of feelings of control and mortality with older adults, Krause and Shaw (2000) commented: “it is important to evaluate feelings of control that are associated with specific life domains” (p 618), because: “older adults are likely to feel they can exercise more control over some areas of life than others” (p 618). This may also be true of adults in midlife. This second study evaluated feelings in relation to a
specific area of life, but, despite the study’s protocols, it is impossible to determine to what extent the scales assessed feelings specific to menopause, or tapped into more general feelings.

Krause and Shaw (2000) also make a distinction between primary and secondary control: “primary control refers to efforts aimed at changing the external environment, whereas secondary control is concerned with changing internal cognitions” (p 619), concepts similar in some ways to those of internal or external loci of control (Rotter, 1966). In this study, the Pawn Scale was used to measure feelings of helplessness, a concept related to an external locus of control. It is encouraging that women’s scores improved on this measure. It could be interpreted as an indication that women’s feelings of control in relation to the external environment had improved.

Women’s Origin Scale scores, related to an internal locus of control, improved in the short time, but not the longer term. This may have reflected a temporary, but not sustainable, increase in internal feelings of control, in the context that all of these women already had above-average Origin Scale scores before the workshop.

The second factor that must be considered relevant to the short-term nature of women’s improvement in positive feelings is the design of the Menopause Workshops. Five months after the brief workshops the women felt less uncertain and helpless about their choices, indicating that they may have moved from anxiety to engaging in decision-making. They also showed some short-term increases in feelings of control, hope, and positive feelings. I discussed earlier the possibility that a longer intervention may be more appropriate for achieving longer-lasting satisfaction with decision-making during the menopausal transition, and therefore increases in feelings of control, hope and positive feelings. The workshop outline allowed the possibility of delivering six sessions, rather than three. In this study I chose three sessions to accommodate the needs of busy women, and the retention rate was 100% at Time 2, and 99% at Time 3,
with only one woman whom I could not contact at Time 3. It may be that offering the workshop over six sessions would allow women to achieve more lasting positive feelings, however it would carry the risk that the commitment of time might be too great for working women, with a consequent reduction in the retention rate (Yalom, 1975/1995).

Also, the Personal Construct Model of Menopause predicted that when a woman is able to elaborate her construing in a context where she feels well-informed, she is likely to move through the C-P-C Decision-making Cycle to make satisfying choices in reconstruing herself, and she will experience an increase in feelings of control, hope and positive feelings. It may be that the brevity of the workshops was a barrier to sufficient information being exchanged. It is possible that women did not feel sufficiently well-informed to sustain the choice/control phase of the C-P-C Cycle, and their feelings of control, hope, and positive feelings. Alternatively, I may have been wrong in my assumption that I could use measures of control, hope and positive feelings as an indicator that women had completed the C-P-C Cycle. I shall consider this further in Section 10.3.

There is another question to consider in reflecting on the findings of Study 2: Why were there no differences at Time 1 between Samples A and B, other than levels of distress? In the analyses of Samples A and B, I found no significant differences between samples at Time 1, yet women had been allocated to a sample on the basis of differing levels of distress. In addition, in the second set of analyses, significant differences were found at Time 1 between the Workshop Samples and the Contrast Sample on measures of anxiety and helplessness. So although the differences between Samples A and B were not significant on these measures, these two Workshop Samples were significantly different from the Contrast Sample. An explanation for this might lie with the homogeneity of the samples. The three samples of women were
drawn from a population of women who volunteered to take part in a menopause study, and the samples were well-matched on socio-demographic characteristics. It is conceivable that the positive measures reflected that similarity between samples, but that the women who were more uncertain, and felt a greater degree of helplessness, volunteered for the workshops, resulting in differences that were found between the Workshop Samples and the Contrast Sample on these measures.

There may also be factors that were not measured that may have played a role in achieving the effect. The women in the Menopause Workshop groups, which were based on existing workplace groups, represented a mix of Samples A (Above average distress), and B (Normal distress). The workshop may have been effective for the women in Sample A, because of their interaction during the workshop with the women in Sample B, and vice versa. To test this, it would be necessary to design a study with women with above average, or normal, levels of distress, in separate groups, in addition to a mixed group such as in this study.

The significant results, in the reduction of anxiety and feelings of helplessness, achieved in this brief intervention are in some ways similar to the results of Viney, Clark, Bunn and Teoh (1985) in provision of brief crisis counselling. In that study many patients had only one or two counseling interactions and few had more than four. The researchers comment that: “the unusually powerful effects of the counselling intervention can be attributed to its provision during a period of crisis for the patients … people in crisis are open to change” (p 63). Although the women in this study did not commonly experience menopause as a crisis, it was clear that it meant a significant transition for some. As Viney (1995) says: “transitions give people opportunities to revise their construing” (p 113). When women experience menopause as significant it may well present an opportunity for change similar to that experienced in crisis.
10.1.2.3 Limitations of Study 2

A Consolidated Standards of Reporting Trials (CONSORT) statement was developed in the 1990s to improve the quality of reporting of randomised, controlled trials (Begg, Cho, & Eastwood, 1996). The statement was developed by an international group, which included clinicians, statisticians, and biomedical editors, and was accepted by bodies such as the International Committee of Medical Journal Editors (Moher, Schulz, Altman, & for the CONSORT Group, 2001a). In 2001, a revised statement was published in The Lancet (Moher et al., 2001a), and the Journal of the American Medical Association (Moher, Schulz, Altman, & for the CONSORT Group, 2001b). The statement includes a 22-item checklist covering all aspects of clinical trials. In terms of these criteria, the key limitations in Study 2 were in relation to sampling.

Sampling

The lack of randomisation in the original selection of the women, and in assignment of the women to samples, allows the possibility that effects found in the study were biased as a result of the composition of the samples. Sampling was purposive, in that it was directed predominantly to women at work, and the sample differed from the general population in other ways. The two major occupational classification levels represented in the sample were the Professional level and the Intermediate Clerical, Sales and Service Worker level (Australian Bureau of Statistics, 1998). These classifications also represent the occupational levels with the highest rate of women’s participation in the general population, but they occur at a much lower rate. Similarly, educational levels were different here from the general population, with a greater proportion of women in the sample holding a degree or a vocational qualification.
A number of factors may have influenced this aspect of the sampling. Firstly, this study was particularly concerned with women at work, but it was not restricted to professional women. Invitations to participate were circulated via staff networks at professional and non-professional levels in the organisations concerned. Secondly, although both interviews and interventions were offered at the workplace, or study, locations to minimise disruption to women’s lives, women working at a professional level may have had more choices in organising their work schedules than, for example, women working in a clerical position. Women working as clerical officers may have had less control over deadlines that managers might impose, that might conflict with the lunch break, or the time for leaving work. This lack of control may have inhibited such women’s willingness to commit themselves to participation in a workshop at fixed times. Thirdly, professional workers tend to have more privacy at the workplace, and this may have contributed to a degree of autonomy that facilitated participation. Women working at a nonprofessional level, who had less power in the workplace, may have felt less confident about participation, either because participation could have been seen as exposing in some way, or because they perceived a lack of value in their own contribution. Finally, these women may have found the research irrelevant, and not important in comparison to their other tasks. The research would have been improved by a greater level of preliminary consultation with non-professional women, to ascertain the activities and arrangements that would be most convenient for them.

There are other sampling issues that might be relevant to the limitations of the study. More women volunteered for Study 1 than could be accepted within time constraints. Women continued to volunteer after Study 1 had been completed, as they were eager to talk about what menopause meant for them. In contrast, fewer women volunteered for the menopause workshop intervention. Menopausal status may be a relevant factor in explaining this difference. Participation in Study 1 was not restricted
by menopausal status or type of menopausal experience. By contrast, the invitation to take part in the workshops was directed to premenopausal, perimenopausal and menopausal women and may have been interpreted by women as being most relevant to women experiencing troublesome symptoms. This may have restricted the pool of volunteers.

An analysis of Study 1 transcripts revealed that of the women interviewed in Study 1 who did not take part in the intervention, only 10.2% showed higher than normal levels of distress. Using this level of emotion as a guide to whether the women experienced the need for change, the figure suggests that few of the non-intervention samples of women felt that need. As noted in Chapter 8, discomfort, or in PCP terms an awareness of the need for change, may often be a precondition for a person volunteering to take part in a process that may lead to change (Perley, 1979). This self-selection could be used to advantage in future research if the aim were to target resources to those most in need, but it is useful to know that the workshops appeared to be of benefit to women with higher, and with normal, levels of distress.

The taboos traditionally surrounding menopause may have been a factor affecting the sampling. It is expected in this society that women will manage their experience of menopause in such a way that it will not disrupt or interfere with their working or family life in a significant way. In working life, menopause, like menstruation, is generally invisible. Some women may have felt uncomfortable about taking time to explore this topic.

A further factor may have been a reluctance to volunteer by women who construe menopausal changes as natural. For these women, however distressing their symptoms, a need for exploration may, in their construct systems, mean a failure as a ‘natural’ woman. Women may have seen participation as an admission that they were not in control, and it may have challenged their constructs about managing ‘invisibly’
and/or ‘naturally’. In the light of these factors, it is understandable that while women might have been ready to talk about their experiences in an interview, on a once-only basis, they were less ready to volunteer to take part in an activity that required a greater commitment of time, and invited an exploration of choices in relation to menopause.

Purposive sampling using volunteers, although appropriate for this initial study, limits the possibility of generalisation from the findings, and the wider applicability of the work. A larger scale study, with a more representative range of participants, would provide more convincing data.

**Allocation to Sample**

The use of a Contrast Sample, rather than an experimental Control Sample, limits the conclusions that can be drawn from comparisons between the Workshop and Contrast Samples. It was women’s preferences, rather than randomisation, that determined women’s membership of either the Workshop or Contrast Samples. Allocation to either Sample A (Above average level of distress), or Sample B (Average level of distress), however, was on the basis of a computerised screening analysis of women’s initial levels of distress.

**Independence of Scoring**

I did not record this sample membership in such a way that would identify individual items of data in these terms. Women’s sample membership was recorded on my SPSS database for use in the statistical analyses, but data were identified solely by an identification number. I undertook the scoring of the outcome measures, and I was unaware of sample membership at the time. I was however aware of whether I was scoring Times 1, 2, or 3, because of the passage of time separating the data collections. The inter-rater reliability trials, however, drawn from a mix of data collection times, showed a high correlation between my scoring and that of the independent raters. The
study would have been strengthened by the use of independent scorers, who were unaware of sample allocation, and time of data collection.

**Screening**

As a screening tool, I used the Depression Content Analysis Scale (Gottschalk & Bechtel, 1990), which was scored using the PCAD computer program (Gottschalk & Bechtel, 1990). I theorised that this scale could be used as a measure of distress. Other measures, such as of anger, could, however, be used to assess distress. Alternatively, two measures could be used for screening, to provide a higher level of sensitivity in the screen.

**Validation of Treatment**

There was minimal validation of treatment in this study. Viney (L.L. Viney, 1998) suggested that treatment validation could be achieved by taping therapy sessions for evaluation by independent experts, or by collecting data from both client and therapist during or after sessions. I used a Diary Record Sheet to record my responses during the workshop sessions, to try to make my own construing transparent, but this material was not evaluated by an independent expert. I also collected evaluation data from the women immediately after the workshops, but they were not asked to reflect on the method of treatment as such.

In terms of the validity of the treatment for different types of clients (Chambless & Ollendick, 2001), the findings were that, for the women involved in the study, the treatment was beneficial for women with above average, as well as normal, levels of distress. This suggests that the treatment could be undertaken with a wider range of women without risk.

**Dependent Variables**

The dependent variables in this study were scores on five content analysis scales. I used content analysis scales for their ability to draw meaning from the
women’s own words, in a non-obtrusive way, without the imposition of my own concepts. The validity of the content analysis scale scores could, however, have been strengthened by their use in combination with other measures, such as standardised questionnaires to provide confirmatory data. For example, although they measure different concepts, a test such as the Beck Anxiety Inventory (Beck & Steer, 1993) could have been used in addition to the Cognitive Anxiety Scale, to assess women’s general feelings of anxiety.

Other states could have been useful measures of the effects of group work. Women’s perceptions of themselves as more likely to take initiative (a helpful maturational state), and less likely to have confidence in their own judgment (a less helpful maturational state), could have been assessed before and after the workshops, using the Content Scales of Psychosocial Maturity (L. L. Viney, Rudd, Grenyer, & Tych, 1995).

The predictions of the personal construct model of menopause about positive emotions were supported in the short term, but not supported in the longer term. This may have been related to factors such as the brevity of the workshop, as discussed earlier. It may be, however, that this effect might have been related to the measures used. The use of alternative, or additional, measures would help in providing evidence on this point, bearing in mind, however, that the best solution uses the fewest variables possible to ensure suitable power for the analysis (Tabachnick & Fidell, 1989).

Summary

In summary, the limitations of this study restrict my ability to generalize from the encouraging outcomes. The findings indicate only that other women with comparable characteristics, in comparable situations, may experience similar changes. In addition, questions about the findings remain, because of the restricted sampling, and issues of data collection, validation of treatment, and measurement.
10.2 The Relationship Between the Quantitative and Qualitative Data

In this research, there was an interweaving of qualitative and quantitative data. Study 1, qualitative research, and Study 2, which combined qualitative and quantitative methods, were linked by two factors. Firstly, some women from Study 1 also continued into Study 2. Secondly, I developed the Menopause Workshop as a response to the strong themes of distress, difficulty in decision-making, and a lack of opportunities for discussion, that I identified through qualitative analysis in Study 1. The qualitative data I gathered in Study 1 therefore provided the impetus for Study 2.

In Study 2 there was a further relationship between qualitative and quantitative data. In that study, quantitative data were obtained by applying content analysis scales to women’s written meanings of menopause, a method that combined the strengths of both qualitative and quantitative data collection methods. These written examples of women’s construing were not only measured to produce scores of emotions, but could be qualitatively examined for changes in construing to illustrate changes in scores. Qualitative data also enriched the quantitative findings by providing a fuller picture of women’s changes in construing as they participated in the study. Examples of women’s non-verbal construing, for example in drawings, and from my own diary record of the workshops, provided additional sources of qualitative data. In summary, the use of these complementary methods was a satisfying and meaningful way to accurately represent women’s experience of menopause, allowing clinically significant, as well as statistically significant interpretations (Jacobson & Truax, 1991) to be made.

10.3 Implications of Study 2 Findings for the Personal Construct Model of Menopause

The Personal Construct Model of Menopause predicted that:
1. When a woman is able to explore her individual meanings of menopause by sharing her experience, the elaboration of her constructs and her engagement in the Creativity Cycle will be facilitated;

2. When a woman is able to elaborate her construing in a context where she feels well-informed, she is likely to move through the C-P-C Decision-making Cycle to make satisfying choices in reconstruing herself, and she will experience an increase in feelings of control, hope and positive feelings; and

3. When a woman has opportunities to make satisfying choices in reconstruing herself in relation to menopause, her predictions are more likely to be validated and she is likely to experience a reduction in the emotions of transition such as anxiety, and an increase in feelings of control, hope and positive feelings.

The predictions based on the model, which I tested in Study 2, were largely confirmed in the short term by the findings of that study. In the longer term, however, the predictions about the positive emotions were not confirmed. These findings suggest that some modification of the assumptions of the model should be considered. The linking of feelings of control, hope and positive feelings, firstly to the completion of the C-P-C Cycle, and secondly to a reduction in emotions of transition, such as anxiety, is open to question. It is likely that the model conflated some of the processes involved, and linked emotions that do not necessarily occur in parallel. The model would be clearer, and testing could be more precise, if processes such as elaboration, engagement in the C-P-C Decision-making Cycle, making informed choices, and validation, were separately considered. I therefore propose a revision to the personal construct model of menopause: a revised Structural Pattern for intervention, which has four propositions.

*Structural Pattern: Intervention*
1. When a woman is able to explore her individual meanings of menopause by sharing her experience, she is likely to elaborate her constructs, and her engagement in the Creativity Cycle will be facilitated;

2. When a woman is able to elaborate her construing, and engage in the Creativity Cycle in a context where she feels well-informed, she is likely to engage in, and move to completion of, the C-P-C Decision-making Cycle, perceive herself as more likely to take initiative, and experience a reduction in the emotions of transition such as anxiety;

3. When a woman perceives herself as more likely to take initiative, and feels she is making informed choices in reconstruing herself in relation to menopause, she is likely to experience an increase in feelings of control; and

4. When a woman’s choices are validated, she is likely to experience feelings of hope and positive feelings.

In developing the model, I was guided by Viney’s (Linda L. Viney, 2001) criteria for personal construct models. The criteria are that the model should be soundly based in personal construct psychology, clearly articulated, internally consistent, parsimonious, relevant to events that are important, comprehensive, and specific enough for action (Linda L. Viney, 2001). The earlier version of the model was perhaps too parsimonious, and the revision is an attempt to improve its comprehensiveness, and its specificity for action.

10.4 Implications of Study 2 Findings for the Menopause Workshop

In speculating about factors that may have contributed to the positive findings of Study 2, I have identified three issues that may be important. Firstly, the workshops were ‘process rich’. Using a diversity of means of making meanings explicit may have helped the development of alternative constructions in a short time. Ravenette (1999), for example, has found non-verbal techniques very useful for this purpose. Secondly, I used strategies such as “pregroup preparation, homogeneous composition, and
structured interventions” (Yalom, 1975/1995, p 63), as well as pre-existing groups, to promote cohesiveness early in the life of the group. Thirdly, it is likely that the size of the groups was important. According to Yalom (1975/1995), a comparison between 12-member and five-member problem-solving groups, indicated that the larger groups were more dissatisfied and showed less consensus than the small groups. There was a maximum of 8 women in any group, and this number fits well within a personal construct framework (Dunnett & Llewellyn, 1988; Winter, 1992).

Of course, it remains possible that the length of the menopause workshop was not sufficient to achieve a lasting improvement in women’s feelings of control, hope and positive feelings. It would be necessary to test the workshop with different numbers of sessions to confirm whether this is a relevant factor. It is important to bear in mind Yalom’s (1975/1995) warning, however, that the high dropout rates for many groups reflect the fact that many “group therapy members ‘choose’ brief group therapy, even if the therapist has longer-term plans” (p 273), and the retention rate for this study was 100% at Time 2, and 99% at Time 3, when one woman was uncontactable.

10.5 Issues Involved in Working with Women Construing the Menopausal Transition

In Study 2, the workshop that I tested was based on a groupwork approach. Individual work with menopausal women, however, would be possible. In that case, the researcher would take on more of the responsibility for validating and invalidating construing, and providing alternative constructions, which was provided by the other women during groupwork.

During the running of the Menopause Workshops it became apparent that it was not ideal to attempt the workshops with only one group leader/researcher. The intensity of the processes of the workshops, and the emphasis on small group, and
dyadic, work, made it difficult to ensure that individual and group interests were always met. I recommend that, in future, the workshops always be run with two group leaders/researchers, and responsibility for participation in small groups be shared between the two.

In Chapter 9 I made other recommendations that would improve future use of the workshops, and should be considered during the planning phase. Firstly, in workplaces, or other organisations, differences in status should be considered. It may not be appropriate to mix staff from different occupational levels or sub-cultures, and separate workshops may have to be considered. If, however, a group were to consist of women from different levels, offering more sessions might provide greater opportunities for integrative activities. Secondly, workshops undertaken in the workplace should include processes, such as a discussion of context-specific construing, to assist the women to distinguish their constructions of workplace relationships, and bind these to their specific context.

10.6 Directions for Future Research

10.6.1 *The Contribution to the Research by the Participating Women*

The qualitative and quantitative findings of this research show the importance of attending to women’s own meanings of menopause. Research that lacks a method that includes the active participation of the women, will fail to convince of the validity of its findings. Study 1, which involved qualitative research methods, produced rich data about the meanings of menopause for that group of women. This information then informed the development of a personal construct model of menopause, and a menopause workshop, which was evaluated in Study 2. In Study 1, 50% of women mentioned a medical or health issue as one of their meanings of menopause, and 43% referred to doctors, and constructions of what doctors had said or meant. Many women expressed frustration about medical mismanagement, a lack of understanding, and a
search for help. Seventy-four percent of women expressed distressing emotion, which ranged from anxiety to anger, indicating that they were experiencing a time of transition, with a need for change in their construct systems (Kelly, 1955/1991a). At a transitional time, when they needed help, these women had not, in general, had their experiences and meanings taken into account by healthcare providers, a similar finding to another Australian study (Berger & Forster, 2001). The women clearly expressed a need for an opportunity to explore their own experience of menopause, to assist with decision-making. The findings of Study 2 appear to indicate that they may have found that opportunity in the Menopause Workshop. These findings underscore the importance of basing research designs on the contributions of the experts, the women themselves. The issue is even broader than this. Health care for women at menopause, as Murtaph (2003) has urged, would be improved if health care practitioners, researchers, and policymakers, would “actively engage with women’s meanings and experiences” (p. 9).

In Chapter 5 I discussed my research framework, and the strategies I developed as a guide for cooperative research with women. The approach outlined in that framework, such as inviting co-researchers to contribute to the interpretation of the research, are crucial for the validity of research. Other strategies, such as ensuring that the research process be carried out in a way that respected the other demands of women’s lives, and that the women be invited to guide decision-making on group formation and membership, and location of interviews, are equally crucial in providing a context in which women can participate as freely as possible. As other research has indicated (Robinson & Stirtzinger, 1997), taking the research to the women, rather than the reverse, should enhance participation. This, in turn, should strengthen the findings, by including women who might not normally form part of research populations,
bearing in mind the fact that the proportion of eligible people who participate in studies is low (Hepworth, Paine, Miles, Marley, & MacLennan, 2002).

Future studies should build on the combination of qualitative and quantitative approaches used in this study. Women’s construing, recorded in any one data collection procedure, can be explored using qualitative techniques to produce rich information. In addition, it can be analysed to produce quantitative data by using content analysis scales.

10.6.2 Randomised Experimental Design

There are design and methodology issues that should be addressed in future research into menopause workshops.

1. A randomised controlled trial is the accepted standard for demonstrating the reliability of findings (Moher et al., 2001a). It is therefore important for such a trial to be carried out for the workshop to be evaluated according to international standards. It is encouraging that the Menopause Workshop appeared to have a beneficial effect for women with normal levels of distress, as well as women with above average levels of distress, which suggests that further research evaluating these workshops, with more representative samples, should be undertaken.

2. Stratified sampling techniques should be used to ensure that more representative samples of employed women are included. In addition, it would be useful to extend sampling to include women who are unemployed but looking for work, and women who are not occupied outside the home, to ascertain if the workshop would be beneficial for those samples of women.

3. It would be an advantage to make independent the tasks of group leaders and data collectors to increase confidence in the reliability of results.

4. Additional states could be used to evaluate the workshops. The use of a standardised tool such as a questionnaire could be considered in addition to the content
analysis scales used in Study 2, to add validity to the findings. Alternative states could also be considered, such as women’s perceptions of themselves as more likely to take initiative, and less likely to have confidence in their own judgment, using the Content Scales of Psychosocial Maturity (L. L. Viney et al., 1995).

5. A process should be undertaken to ensure validation of the workshop treatment. For example, tape recordings of workshop sessions could be examined by an independent expert to verify whether the treatment matched the stated therapeutic guidelines. Data could also be collected from the therapist and participants during and after the workshops.

10.6.3 Alternative Configurations of Workshop Groups

It would be useful in future research to test some different configurations of workshop groups. I offer some suggestions:

1. Test whether mixed or separate occupational groups are most effective, for example, professional and non-professional women, or employed and non-employed women. The method should include a preliminary consultation phase, to ascertain the arrangements that would be most convenient for the different groups of women. When they are included in one workshop group, groups of women representing different occupations should be separately consulted about issues such as the timing and location of workshops, to ensure that arrangements are as convenient as possible.

2. A further issue, which I have already raised, is that it would be useful to run a study with women with above average and normal levels of distress in separate groups, in addition to a mixed group such as was used in this study, to test which configuration is most effective.

3. Alternatively, the initial screening procedure, that determined women’s levels of distress, could be useful in future research to ensure that resources are targeted to those most in need.
4. In a related issue, the workshop could be tested with six, as well as three, sessions to confirm whether this is a relevant factor in producing an effect. The findings of Study 2 do not indicate whether women’s levels of distress should influence the number of sessions, although it is possible that a greater number of sessions might be more effective for women with higher levels of distress, and that workshops could be tailored to the needs of the women. For example, women with higher levels of distress could be offered six sessions, whereas women with normal levels of distress could be offered three sessions of the workshop.

5. In Study 2, women were not assigned to samples on the basis of menopausal status, although the workshops were restricted to women within the menopausal age range. In future research it might be useful to advertise and conduct separate workshops for premenopausal women, and women already experiencing symptoms, that is, perimenopausal and menopausal women. Although a diverse sample contributes to the richness of the elaborations, it is possible that in some instances the needs of premenopausal women might conflict with the needs of perimenopausal and menopausal women, and vice versa.

6. More than half of the women in this research, who had actually experienced menopause, volunteered that menopause had meant some difficulty for them at work. Future studies might usefully investigate the part social context plays in women’s experience of menopause. If sampling were conducted as suggested above, comparisons could be made between women’s experiences in different settings. One hypothesis to be tested could be whether women occupied outside the home find menopause less distressing than women who are at home, as the medical evidence suggests (Hom, Chan, Yip, Chan, & Sham, 2003) (Greene, 1992).

7. It would be useful to conduct research, and workshops, with groups of women whose needs during menopause have been poorly addressed, or not addressed
at all. As I noted in Chapter 2, these include women with disabilities, women who experience premature menopause, and perimenopausal new mothers. It would also be valuable to record the coping strategies of these women to use in further workshops.

8. In the women’s evaluations of the workshops, a minority of women indicated that they would have liked more sessions in the workshops. One woman specifically recommended that a discussion on drugs be included which was not surprising given the controversies about the use of hormone replacement therapy. The Menopause Workshops were based on the idea that women needed to explore their menopausal meaning and decision-making. Offering this opportunity in conjunction with the provision of medical and complementary treatment information, would perhaps result in more lasting feelings of control and satisfaction for the women. In that case, it would be most advantageous to offer the workshop following the medically oriented session.

10.7 Conclusion

In the “onrushing sound and fury of life” (Kelly, 1955/1991a, p 486), and amidst the “puzzling problems” (Kelly, 1955/1991a, p 486) occasioned by transition, and the challenges of “The Change,” the changing meanings of the women portrayed in this research offer some hope. In general, the overall objectives of the studies that I have reported were met. In Study 1, I used a personal construct approach, to identify and explore the meanings that a sample of women, occupied outside the home, used in construing the experience of menopause. I identified a need for those women to explore their experience. In Study 2, the overarching aim of the Menopause Workshop was to address that need. The more specific aims were: (1) to reduce the women’s anxiety and feelings of helplessness in relation to menopause, and (2) to increase the women’s feelings of control, hope and positive feelings in relation to menopause. The findings were that Aim 1 was met in the short and longer term. Aim 2, however, was
met in the short term, but not in the longer term. It is interesting that women’s meanings of menopause in this research showed a long-term reduction in feelings of anxiety and helplessness after a very brief personal construct workshop. This is an encouraging result in an age of financial restrictions on health services, and increasingly ‘time-poor’ workers, when brief interventions, and group programs, are becoming more important. The results of these studies add to the existing body of personal construct research in demonstrating that the anticipatory, creative, and cooperative, nature of a personal construct approach provides a basis for personal construct psychology to play a convincing role in meeting the need for effective provision of time-limited psychological services.
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REFERENCES


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APPENDIXES
APPENDIX A

Themes relating to the Personal Construct Model of Menopause

Meaning 1

Menopause means change that lies within the range of convenience of a woman’s construct systems and is consistent with her predictions about herself.

Structural Pattern 1: Limited Change

Theme: No change
Description: Minor change
   Validation of gender related predictions
   No need for change

Structural Pattern 2: Hostility

Theme: Hostility
Description: Impermeable constructs
   “No change” stated, but changes, or symptoms, described

Meaning 2

Menopause means significant physical and/or psychological change that lies outside the range of convenience of a woman’s construct systems and invalidates the predictions of a woman trying to anticipate events by construing their replications

Structural Pattern 3: Limitation and Invalidation

Themes
- Aware of change
- Inability to predict, including
   Discussion limited
   Information conflicting or limited
• Inability to control changes
• Expressions of distressing emotion

Description

Aware of change
Confusion, unable to predict
Unable to elaborate construing
Unable to move to control, choice or creative reconstruction
Emotions of transition

\textit{Structural Pattern 4: Reconstruction and Validation}

Themes

• Exploration and elaboration, including
  
  Discussion
  Information gathering

• Reconstruction and acceptance

• Able to control and make satisfying choices

• Validation of predictions

Description

Engagement in C-P-C decision-making cycle, including

Construction of change,
Exploration and elaboration, information gathering and discussion

Reconstruction and acceptance

Construction of change
Satisfying choices
Validation of predictions
Reduction in distressing emotions

APPENDIX B

Australian Standard Classification of Occupations

1 Managers and Administrators
2 Professionals
3 Associate Professionals
4 Tradespersons and Related Workers
5 Advanced Clerical and Service Workers
6 Intermediate Clerical, Sales and Service Workers
7 Intermediate Production and Transport Workers
8 Elementary Clerical, Sales and Service Workers
9 Labourers and Related Workers

**Major Group 1  Managers and Administrators**

Managers and Administrators head government, legislative, industrial, commercial, agricultural and other establishments, or departments within these organisations. They determine the policy of the organisation or department, and direct its functioning, usually through other managers, and coordinate economic, social, technical, legal and other policies.

Most occupations in this major Sample have a level of skill commensurate with a bachelor degree or higher qualification or at least 5 years relevant experience.
Major Group 2  Professionals

Professionals perform analytical, conceptual and creative tasks through the application of theoretical knowledge and experience in the fields of science, engineering, business and information, health, education, social welfare and the arts.

Most occupations in this major group have a level of skill commensurate with a bachelor degree or higher qualification. In some instances relevant experience is required in addition to the formal qualification.

Major Group 3  Associate Professionals

Associate Professionals perform complex technical and administrative support functions that require an understanding of the underlying theories and methods of a particular field and significant practical skills. Tasks are often performed in support of professionals.

Most occupations in this major group have a level of skill commensurate with an AQF Diploma or higher qualification or at least 3 years relevant experience. In some instances relevant experience is required in addition to the formal qualification.

Major Group 4  Tradespersons and Related Workers

There were no participants in this category.

Major Group 5  Advanced Clerical and Service Workers

Advanced Clerical And Service Workers perform a range of complex organisational, administrative, service and liaison tasks requiring a degree of independence, discretion, and judgement. Most occupations in this major group have a level of skill commensurate with an AQF Certificate III or higher qualification or at least 3 years relevant experience. In some instances relevant experience is required in addition to the formal qualification.
**Major Group 6  Intermediate Clerical, Sales and Service Workers**

Intermediate Clerical, Sales And Service Workers perform a range of clerical, sales, and service tasks requiring a limited degree of discretion and judgement.

Most occupations in this major group have a level of skill commensurate with an AQF Certificate II or higher qualification or at least 1 year’s relevant experience. In some instances relevant experience is required in addition to the formal qualification.

**Major Group 7  Intermediate Production and Transport Workers**

Intermediate Production and Transport Workers operate plant, machinery, vehicles and other equipment to transport passengers and goods, to move materials, to generate power and to perform various agricultural, manufacturing and construction functions.

Most occupations in this major group have a level of skill commensurate with an AQF Certificate II or higher qualification or at least 1 year’s relevant experience. In some instances relevant experience is required in addition to the formal qualification.

**Major Group 8  Elementary Clerical, Sales and Service Workers**

Elementary Clerical, Sales And Service Workers perform a range of clerical, sales and service tasks, usually under supervision, within established routines and procedures. Most occupations in this major group have a level of skill commensurate with completion of compulsory secondary education or higher qualification.

**Major Group 9  Labourers and Related Workers**

Labourers And Related Workers perform routine tasks usually working under close supervision. Most occupations in this major group have a level of skill commensurate with completion of compulsory secondary education or higher qualification.
APPENDIX C

Information Sheet

The Meaning of Menopause

This research is being conducted by Heather Foster as part of a Ph.D. in Psychology supervised by Associate Professor Linda Viney in the Department of Psychology at the University of Wollongong.

The aim of this research is to explore the experience of, and expectation of, menopause with pre-menopausal, menopausal and post-menopausal women. You will be asked for details of your age, age at onset of menopause if applicable, current or past treatment for menopause, type of employment if applicable.

You are asked to participate in a focus group discussion or interview where you will be asked about your experience or expectation of menopause. The discussion will be recorded on audiotape.

Any information that you give will be treated confidentially and will not be disclosed by the researcher in any form that could identify you. A subject number rather than your name will be used for identification purposes. Reporting and/or publication of the research findings will not identify individuals unless you give written permission. All participants are advised of the need to respect confidentiality when working in a group, as confidentiality is dependent on the commitment of each participant.

If you would like to discuss this research further please contact Heather Foster on (02) 9818 2227 or Associate Professor Linda Viney on (02) 4221 3693. If you have any enquiries regarding the conduct of the research please contact the Secretary of the University of Wollongong Human Research Ethics Committee on (02) 4221 4457.
APPENDIX D (i)

Consent Form (Interview)

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I, …………………………………………………………………………..consent to participate in the research conducted by Heather Foster as it has been described to me in the information sheet. I understand that the data collected will be used for an analysis of the meanings of menopause for women at pre-menopausal, menopausal and post-menopausal stages of life and I consent for the data to be used in that manner.

I agree to the audiotape recording of the interview. I understand that personal details and other information given about me in the course of the research are confidential and that neither my name or any other identifying information will be used or published without my written permission. My participation in this research is voluntary and I understand that I am free to refuse to participate or withdraw from the research at any time without affecting my relationship with anyone connected to the study.

Signed ……………………………………………………..

Date …………………………………..
APPENDIX D (ii)

Consent Form (Group discussion)

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Signed ...................................................

Date ..................................................
APPENDIX E

Questionnaire 1

The Meaning of Menopause

The following information will help in analysing the meaning of menopause for pre-menopausal, menopausal and post-menopausal women. I am asking for your age so that the research can highlight the way menopause can occur, and is experienced, across a great range of ages.

Age …………

Age at onset of menopause (if applicable) ………………

Are you currently, or have you in the past, been given treatment related to menopause?

What is/was the treatment?

Are you employed? ……………

What is your job? ………………………………………………………………………..

Please indicate your highest educational qualification

   School
   TAFE or other post-secondary college
   University

Are you currently taking treatment related to menopause?

If so, what is it?

Thank you for filling in this form.

Heather Foster
APPENDIX F

Interview Schedule

All women:

1. What does/did menopause mean for you?
2. What do you think menopause means for other people?
3. Does/did menopause mean changes in your life? What sort of changes?
4. How do you feel about getting older?

Menopausal and post-menopausal women:

5. What is/was good about menopause?
6. What is/was bad about menopause?
7. Has/did menopause change/d the way you think about yourself?
8. Are there any factors that you think affect/affected your experience of menopause?
## APPENDIX G

### Themes Identified in Study 1 with Descriptions and Examples

<table>
<thead>
<tr>
<th>Theme and Description</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>No change</td>
<td>“I don't feel that much different”; “It did not mean anything, it sort of came and went.”</td>
</tr>
<tr>
<td>Hostility: Stating that there is no change, but describing symptoms, or dealing with change.</td>
<td>“I'm trying to live as if it’s not making any change at all”; “Can’t say that it has stopped me from doing very much at all … I challenge it.”</td>
</tr>
<tr>
<td>Awareness of change, in relation to:</td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>“It was the fact that aging was going to speed up that was a great concern.”</td>
</tr>
<tr>
<td>Body</td>
<td>“What I know is your figure changes because of the hormonal effect.”</td>
</tr>
<tr>
<td>Memory or mind</td>
<td>“I am losing my memory”; “It means having fuzziness or confusion in my thinking”; “I was having mood changes.”</td>
</tr>
<tr>
<td>Loss of role or loss of control</td>
<td>“Menopause would generally bring to mind the whole idea of a change and loss.”</td>
</tr>
<tr>
<td>Menopause as a marker, symbol, sign, rite of passage</td>
<td>“The end of one stage of life”; “I'm looking forward to that rite of passage”; “Turning a corner, starting a new chapter.”</td>
</tr>
<tr>
<td>Periods: any reference to menstruation</td>
<td>“My bleeding became erratic.”</td>
</tr>
<tr>
<td>Sex or sexual qualities</td>
<td>“I hear that with … menopause you lose your sexual instinct or sexual needs”; “Less interest in sex.”</td>
</tr>
<tr>
<td>Symptoms, e.g. hot flushes, tiredness</td>
<td>“It means getting … more fatigue, more lassitude, less energy.”</td>
</tr>
<tr>
<td>Stigma, denigrating remarks or taboos</td>
<td>“There's a social thing around getting to 40 … there's more getting to 50 … a stigma”; “derogatory messages tossed at them about their sweats, their mood swings, irritability”; “It was too personal, too intimate to say.”</td>
</tr>
<tr>
<td>Inability to predict, feelings of confusion;</td>
<td>“Initially it was confusion”; “I don't know whether it's menopause or whether it is other anxieties”; “My body would do strange things”; “Entering into what I see as an age of uncertainty, and just not knowing.”</td>
</tr>
</tbody>
</table>
## Discussion being limited

- **Conflicting or limited information**
  - "It is all still very unclear. They all give me different stories."

## Inability to control changes, including:

- **Feeling unready**
  - "I didn't feel like I was in control of my body"; "I felt out of control, really, really unhappy."

- **Death**
  - "I've heard it can ... lead to suicide"; "It’s your flag, signals going up that you're mortal."

## Fertility

- "It also means that you can't have children anymore."

## Time

- "I would like to just grab hold of time"; "I won’t have enough time."

## Health issues

- "I have started taking medication for blood pressure"; "It might give me breast cancer."

## Expressions of distressing emotion

- "I can’t bear to live with myself"; "I was angry"; "I probably had a little bit of anxiety about it"; "It came as a great shock to me."

## Exploration and elaboration, including:

### Discussion

- "I'm very interested in that research about bones and oestrogen."

### Information gathering, Exploring construing about HRT

- "I would obviously have to go on hormone replacement therapy"

### Predictions based on mother’s experience

- "My mother went through menopause without any ... consequences or effects."

### Natural process/therapies

- "At the back of my mind I keep saying it's a very natural thing"; "I'm healthy and looked after myself"; "I went to my herbalist"; "I've taken some Chinese herbs."

## Construction of change including:

### Enduring

- "I just lived through it"; "You've just got to deal with it."

### Strategies

- "Changing my diet, changing my habits around coffee, and alcohol"; "if you keep your mental activities going you can stave off ... some of these ... things."

### Satisfying choices (positive expressions)

- "I feel more confident in many ways"; "being on HRT ... I'm really enjoying that ... I found it really helpful."
<table>
<thead>
<tr>
<th>Topic</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Freedom (being free to do as you choose)</td>
<td>“It represents a lot more freedom.”</td>
</tr>
<tr>
<td>Relief (e.g. from periods)</td>
<td>“The positive side is no more worries with the period.”</td>
</tr>
<tr>
<td>Future: looking forward with hope</td>
<td>“It means that you can’t have children anymore, but having now had children that's something to really look forward to”; “in terms of changes … I always think in terms of the positive things because most people who talk about menopause talk about the positive things.”</td>
</tr>
<tr>
<td>Reconstruction and acceptance of change</td>
<td>“I felt I’m wiser now. Much older and wiser”; “I have learnt that your cognitive powers don’t decrease as you grow older and this is wonderful.”</td>
</tr>
<tr>
<td>Control</td>
<td>“I’ve got a little bit more control now than I had … I am on top of a lot of things.”</td>
</tr>
<tr>
<td>Validation of predictions</td>
<td>“This whole period of my life has been really interesting because I’ve made some conscious decisions about my career and … got to a level where … I don’t wish to go any further.”</td>
</tr>
<tr>
<td>Contextual Issues:</td>
<td></td>
</tr>
<tr>
<td>Cultural references</td>
<td>“In the Greek tradition … women with periods aren’t allowed to have holy communion.”</td>
</tr>
<tr>
<td></td>
<td>“My daughter was planning to get married.”</td>
</tr>
<tr>
<td>Family: members of family other than mother</td>
<td></td>
</tr>
<tr>
<td>Lesbian: references to being</td>
<td>“The doctor said … ‘how sexually active have you been?’ And I said ‘I’m gay’”; “They were … heterosexual women … and they've got a different horizon.”</td>
</tr>
<tr>
<td>lesbian, female partner, or lesbian issues</td>
<td>“The stress behind the sort of work that I do”; “Being anxious about meetings or projects.”</td>
</tr>
<tr>
<td>Work: references to workplace or work issues</td>
<td>“That was a bit of a panic thinking about living in poverty”; “I won't have to buy tampons.”</td>
</tr>
<tr>
<td>Money</td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX H
Frequency of Themes Identified in Study 1

<table>
<thead>
<tr>
<th>Themes</th>
<th>Percentage of women referring to theme²</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aware of change/Symptoms e.g. hot flushes</td>
<td>88</td>
</tr>
<tr>
<td>Expressions of distressing emotion</td>
<td>74</td>
</tr>
<tr>
<td>Unable to predict</td>
<td>70</td>
</tr>
<tr>
<td>Aware of change/Changes to <em>Body</em></td>
<td>70</td>
</tr>
<tr>
<td>Aware of change/Awareness of <em>Age</em></td>
<td>62</td>
</tr>
<tr>
<td>Exploration/Prediction on the basis of <em>Mother's experience</em></td>
<td>62</td>
</tr>
<tr>
<td>Aware of change/Periods</td>
<td>57</td>
</tr>
<tr>
<td>Construction of change/ <em>Strategies for coping</em></td>
<td>55</td>
</tr>
<tr>
<td>Exploration/Construing about <em>HRT</em></td>
<td>55</td>
</tr>
<tr>
<td>Reconstruction/ <em>Acceptance</em></td>
<td>51</td>
</tr>
<tr>
<td>Unable to control/ <em>Medical conditions</em></td>
<td>50</td>
</tr>
<tr>
<td>Aware of change/Changes to <em>Mind or memory</em></td>
<td>50</td>
</tr>
<tr>
<td>Aware of change/Marker or significant time</td>
<td>49</td>
</tr>
<tr>
<td>Context/ <em>Work</em></td>
<td>49</td>
</tr>
<tr>
<td>Aware of change/Loss of role, or loss of control</td>
<td>47</td>
</tr>
<tr>
<td>Construction of change/ <em>Relief</em></td>
<td>47</td>
</tr>
<tr>
<td>Unable to control/ <em>Fertility</em></td>
<td>44</td>
</tr>
<tr>
<td>Aware of change/Visits to <em>Doctors</em></td>
<td>43</td>
</tr>
<tr>
<td>Aware of change/ <em>Stigma or taboos</em></td>
<td>42</td>
</tr>
<tr>
<td>Context/ <em>Family</em></td>
<td>39</td>
</tr>
<tr>
<td>No change</td>
<td>38</td>
</tr>
<tr>
<td>Exploration/ <em>Discussion</em></td>
<td>38</td>
</tr>
<tr>
<td>Exploration/Natural process or therapies</td>
<td>36</td>
</tr>
<tr>
<td>Unable to predict/Information conflicting or limited</td>
<td>36</td>
</tr>
<tr>
<td>Construction of change/ <em>Anticipating future</em></td>
<td>34</td>
</tr>
<tr>
<td>Unable to predict/ <em>Discussion limited</em></td>
<td>34</td>
</tr>
<tr>
<td>Construction of change/ <em>Freedom</em></td>
<td>34</td>
</tr>
<tr>
<td>Unable to control/ <em>Death</em></td>
<td>31</td>
</tr>
<tr>
<td>Aware of change/References to <em>Sex</em></td>
<td>31</td>
</tr>
<tr>
<td>Aware of change</td>
<td>30</td>
</tr>
<tr>
<td>Context/Lesbian</td>
<td>27</td>
</tr>
<tr>
<td>Exploration/Information gathering</td>
<td>27</td>
</tr>
<tr>
<td>Construction of change/Satisfying choices</td>
<td>26</td>
</tr>
<tr>
<td>Unable to control</td>
<td>24</td>
</tr>
<tr>
<td>No change stated, but symptoms reported</td>
<td>20</td>
</tr>
<tr>
<td>Construction of change/Enduring</td>
<td>19</td>
</tr>
<tr>
<td>Unable to control/Unready</td>
<td>17</td>
</tr>
<tr>
<td>Unable to predict/Different for everybody</td>
<td>16</td>
</tr>
<tr>
<td>Construction of change</td>
<td>15</td>
</tr>
<tr>
<td>No change/Ignoring</td>
<td>15</td>
</tr>
<tr>
<td>Exploration/References to Germaine Greer</td>
<td>15</td>
</tr>
<tr>
<td>Context/Money</td>
<td>14</td>
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<tr>
<td>Context/References to other Cultures</td>
<td>14</td>
</tr>
<tr>
<td>Exploration/Information gathering/Reading magazines</td>
<td>12</td>
</tr>
<tr>
<td>Reconstruction/Validation/Control</td>
<td>12</td>
</tr>
<tr>
<td>Unable to control/Time</td>
<td>11</td>
</tr>
<tr>
<td>Reconstruction/Validation</td>
<td>8</td>
</tr>
<tr>
<td>Reconstruction</td>
<td>7</td>
</tr>
<tr>
<td>Context/Childbirth</td>
<td>4</td>
</tr>
</tbody>
</table>

1 The keywords in sub-themes are indicated by italics.

2 The total number of women in the study was 74.