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Publication Details

Gavranich, P. (2011). Perspectives of Women in Leadership Roles: Working Through *The Change* (Doctor of Health Science). University of Notre Dame Australia. <https://researchonline.nd.edu.au/theses/54>

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**Perspectives of Women in Leadership Roles:
Working Through *The Change***

Philippa Gavranich

This thesis is submitted for the Degree of Doctor of Health Science of
The University of Notre Dame Australia

2011

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Abstract

The majority of women will experience perimenopausal symptoms (Hickey, Davis & Sturdee, 2005; MacLennan, 2009) with an estimated 20% of those experiencing severe symptoms (Hickey et al., 2005). Many of these symptoms have the potential to directly or indirectly affect work performance including hot flushes and night sweats which are experienced by 85% of perimenopausal women (Baldo, Schneider, & Slyter, 2003). Symptoms may begin several years before the cessation of menstruation and may last well into old age (MacLennan, 2009).

This research sought to explore the perceived impact of perimenopausal symptoms on women in leadership roles: how they managed symptoms; the factors that influenced their decisions regarding treatment options and their recommendations for women in similar circumstances. Information was gathered through in-depth, semi-structured interviews with 17 female leaders. An *interpretative phenomenological analysis* (IPA) was employed to identify salient *themes* from the transcribed narrative. Four *superordinate themes* were identified:

- Distraction, disruption, discomfort and distress
- Soldiering on or taking control
- Keeping up appearances
- It's lonely at the top

Participants reported that contending with the demands associated with a leadership role while experiencing perimenopausal symptoms was often distracting and for some, a source of physical and emotional distress which had the capacity to undermine confidence and work performance. Many reported feeling isolated because of the demands and status associated with their work. This isolation often restricted opportunities to gather and share information about symptoms with other women.

The findings provide valuable insights into the experiences of a unique group of women. These insights inform further research and guide interventions and strategies

that may assist women in leadership who may be experiencing perimenopausal symptoms.

In particular, the findings of this study indicate that women leaders and the health professionals from whom they seek advice and support are often ill-informed about the onset, nature and management of perimenopausal symptoms. Interventions that provide information and support in a timely and sensitive manner will benefit all perimenopausal women and particularly those in demanding leadership roles.

Declaration

This thesis is my own work and contains no material which has been accepted for the award of any degree or diploma at any other institution.

To the best of my knowledge and belief this thesis contains no material previously published or written by any other person except where due acknowledgement has been made.

Candidate.....

Date.....

Acknowledgements

I would like to acknowledge the following people who have made it possible for me to complete this thesis.

My supervisors, Professor Helen Parker and Dr Sue van Leeuwen: exceptional women who exhibit the essential leadership qualities of empathy, patience and wisdom. For their guidance, support and encouragement throughout this project, I am sincerely grateful.

UNDA staff, Dr Marc Felman and Lorraine Mayhew from the Research Office and Librarian Jan Harmsen for their advice and support throughout the past few years.

The women leaders who so generously gave their time to participate in this study: this thesis would not have eventuated if they had not been prepared to speak so candidly about a very sensitive subject.

My mother Paula Manser (dec.) who graduated from The University of Western Australia at a time when women rarely aspired to such achievements. She encouraged me to undertake this research and would have enjoyed seeing me complete the task.

My husband Ben and father Don Manser for their practical and moral support and expressions of confidence in my ability to see this project through to completion.

Chapter One: Background and Context

As women move towards the end of their reproductive lives they enter the menopausal transition which begins with a change in ovarian function and subsequent fluctuations in the levels of reproductive hormones. This period is referred to as perimenopause and is often associated with a range of clinical signs such as irregular menstruation and a number of adverse symptoms such as hot flushes and disrupted sleep patterns. Most women will enter the period of perimenopause somewhere between 35 and 60 years of age (Baldo et al., 2003; Baram, 2005; Cobia & Harper, 2005; Greendale, Lee & Arriola, 1999; Simon & Reape, 2009). The majority of women will experience their final menstrual period somewhere between 45 and 55 years of age with the average age at menopause of 51.4 years (Simon & Reape, 2009).

The period following menopause is called postmenopause and is characterised by an absence of ovulation, no further production of progesterone and very little production of ovarian oestrogen (Baldo et al., 2003; Baram, 2005; Cobia & Harper, 2005; Hickey et al., 2005; Knotts & Childers, 2009; MacLennan, 2009 ; Simon & Reape, 2009).

The majority of women will experience perimenopausal symptoms, with between 20% and 25% experiencing severe symptoms (Davis, 2003; Hickey et al., 2005). Symptoms include a range of vasomotor responses such as hot flushes and night sweats, psychological symptoms including irritability and anxiety, locomotor symptoms such as joint pains and backache and urogenital changes including urinary frequency and dry vagina (MacLennan, 2009). Other symptoms reported include a crawling sensation under the skin, mood swings, depression and concentration difficulties (Baldo et al., 2003; Cutson & Meuleman, 2000; Eun-Ok, 2006; Smith & Michalka, 2003).

According to the Australasian Menopause Society (AMS), there are over two million post-menopausal women in Australia with approximately 80,000 new women reaching menopause every year. Furthermore, these women account for 40% of all visits to health care professional (AMS, 2010 a).

Despite the frequency with which women experience perimenopausal symptoms, research indicates that many are ill-informed about the onset and nature of symptoms as well as the terminology used to describe both the symptoms and phases of the menopausal transition (Lyndaker & Hulton, 2004; Pinkerton & Zion, 2006; Prior, 2006; Twiss et al., 2007).

Research into the impact of perimenopausal symptoms on women in the workplace is scant. Reynolds's papers (1997 & 1999) are among the few substantive reports on the issue. Furthermore, according to Reynolds (F. Reynolds, personal communication, September 24, 2007), there has been little interest in the area following her initial research.

Reynolds's studies and those undertaken more recently by Morris and Symonds (2004), Paul (2003) and Simon and Reape (2009) found that women experiencing certain perimenopausal symptoms while in the workplace, often perceived these symptoms to be disruptive and potentially embarrassing. Furthermore, the study by Simon and Reape indicated that menopausal symptoms had a significant effect on quality of life, physiological, cognitive and psychological functioning, particularly for women in professional roles. In addition, studies by Cutson and Meuleman (2000), and Paul (2003) found that stress, fatigue and other factors associated with both work and the work environment could exacerbate perimenopausal symptoms such as hot flushes.

Of particular significance for this study is the age at which women may be undertaking leadership roles. For example, most Australian women company directors are reportedly in the 45 to 47 year age group (Burgess & Tharenou, 2002) and the average Australian board director (male and female) is between 51 and 70 years of age (Kang, Cheng & Gray, 2007). Data from a study of the CEOs of Fortune 500 companies in the United States (Martelli & Abels, 2010) shows that the 76% of all CEOs in these companies are in the 50-64 year age bracket. With most women entering the period of perimenopause several years prior to actual menopause, it is therefore likely that many women leaders in their late 40s and early 50s will be experiencing perimenopausal symptoms.

For women in leadership roles, perimenopausal symptoms may be an added burden in a working environment where women are often poorly represented and face challenges that may not be experienced by their male counterparts. Women in leadership roles in Australia are in the minority in almost every sphere of industry. Furthermore, women become increasingly isolated as they advance to senior management levels until at the level of Board Director, they are outnumbered by men at 10 to one (EOWA, 2009). In addition, many aspects of being in male-dominated environments have been shown to adversely affect women's physical and mental health (Gardiner & Tiggemann, 1999).

For women who experience particularly troublesome perimenopausal symptoms, there are few effective treatment options. Hormone replacement therapy (HRT) using oestrogen, either with or without progesterone remains the most extensively studied and effective treatment of symptoms associated with low or fluctuating hormones (Knotts & Childers, 2009; MacLennan, 2009). The evidence for HRT's efficacy is well established according to Cochrane reviews of published randomized controlled trials (Baber, O'Hara & Boyle, 2003; MacLennan, 2009). In contrast, no complementary medicines or treatments have been shown to have greater than placebo effect in blinded randomised controlled trials (MacLennan, 2009). Furthermore, not only do many of these therapies and interventions have no evidence-base for their claims of effectiveness, many, including the so called *bio-identical* hormones, reportedly have the capacity for potential harm (MacLennan, 2009).

HRT was first prescribed commercially in the 1920s ostensibly to provide coronary benefits and reduce the risk of osteoporosis, Alzheimer's disease and overall morbidity (Knotts & Childers, 2009). Although the benefits of HRT use were considered to outweigh the risks, a number of long-term placebo controlled, randomised controlled trials investigating various aspects of women's health also included studies of the risks and benefits associated with the use of HRT. These studies include the Women's Health Initiative (WHI), the Women's International Study of long Duration Oestrogen after Menopause (WISDOM), The Million Women Study and The Nurses Health Study which has continued for almost 30 years (MacLennan, 2009).

In 2002, the release of findings from the WHI study challenged the confidence many women and their health professionals had in the safety of HRT use. According to Wren (2009), the study was terminated prematurely due to statistically non-significant increases in the incidence of breast cancer and statistically significant increases in myocardial infarction, thromboembolism and stroke among study participants. In addition, The Million Women Study, which was undertaken in the United Kingdom and published in 2003, also found that HRT increased the breast cancer risk in study participants (Wren, 2009).

Although a number of subsequent reports have cast doubt on the initial findings of the WHI study, adverse media reports caused many women to reconsider and in many cases, to stop using HRT (MacLennan, Taylor, Wilson & Myer, 2004; Hickey et al., 2005; MacLennan, 2009). According to Reape, (K.Z. Reape, personal communication, February 19, 2010) the change in attitude to the use of HRT has had a profound impact on women and the implications of this for symptomatic women in leadership roles remain unclear.

In summary, there are a number of issues which are at the core of this research:

- Most women will experience perimenopausal symptoms.
- Many women are ill-informed about the nature, onset and effective management of perimenopausal symptoms.
- Perimenopausal symptoms have been shown to cause a range of physical and emotional symptoms for women in the workplace.
- The work environment has been shown to exacerbate the effects of perimenopausal symptoms.
- Perimenopausal symptoms may constitute an added burden for women contending with certain demands reportedly associated with leadership.
- The age at which women are likely to be undertaking leadership roles often coincides with the age at which many may be experiencing perimenopausal symptoms.
- A loss of confidence in the use of HRT may have left some women leaders with limited treatment options for problematic symptoms.

Purpose of the Study

The purpose of this study was to explore the impact of perimenopausal symptoms on women in leadership roles. It further sought to identify the coping strategies used by leaders to manage symptoms, their attitudes to treatment options and their recommendations for supporting other leaders in similar circumstances.

It is envisaged that the information gathered during this study may be used to form the basis of educational, counselling and occupational health and safety interventions that may enable women in leadership roles to more effectively recognise and manage their perimenopausal symptoms. In addition, the findings of this study will enable the development of future research projects that more effectively target and explore the issues that are pertinent to this unique group of women.

Research Questions

With consideration of the purpose of the study and based on the seven core issues outlined above, the following research questions were intended to provide a catalyst for discussion and to broadly define the scope of the research topic.

- What are the perceived effects of perimenopausal symptoms on women in leadership roles?
- What are the coping strategies used to manage symptoms?
- What factors influence decisions regarding treatment options?
- What are the recommendations for educating and supporting women in similar circumstances?

Operational Definitions and Terminology

Leadership role.

For the purpose of this study the term *leadership role* has been defined as

A role requiring the management, guidance and direction of a workforce (paid or voluntary) and the responsibility for the development and/or implementation of policy within the organisation.

This definition was used during recruitment of participants to enable prospective participants to determine their eligibility for the study.

The following definitions of the terms that are used in this study are from the Australasian Menopause Society (AMS, 2010 b). As reported earlier, there continues to be confusion regarding the terminology used to describe aspects of the period of changing hormonal function that includes perimenopause, menopause and postmenopause. Many authors use the term *menopause* to refer to the period of time which more correctly includes perimenopause, actual menopause and post-menopause. For the purpose of this study the term menopause will be used as defined below except when cited as a direct quote from a study participant or by another author.

Hormone replacement therapy (HRT)/hormone therapy (HT).

Hormone replacement therapy (HRT) or hormone therapy (HT) is the use of hormones as prescribed during the menopause transition and after the menstrual periods have stopped, to alleviate oestrogen deficiency syndromes such as hot flushes, mood swings, and vaginal dryness and to prevent or treat longer term diseases such as osteoporosis.

Menopause.

Menopause is the final menstrual period and said to have occurred when there has been no period for one year.

Menopausal transition.

The term *menopausal transition* will be used when appropriate in this study to describe the period of changing hormonal function that occurs as women move from pre-menopause through perimenopause, menopause and eventually into post-menopause.

Oestrogen/estrogen.

Oestrogen is a hormone produced primarily in a woman's ovaries. It aids in the development of female sex characteristics and plays an important role in reproduction.

Perimenopause/peri-menopause.

Perimenopause refers to the time from the onset of menopausal symptoms through to the last menstrual period particularly from the onset of irregular periods. It can last for an average of 4-6 years before the periods finally stop.

Although the AMS has chosen to use the hyphenated *peri-menopause* the non-hyphenated *perimenopause* will be used by this author.

Postmenopause/post-menopause.

Postmenopause starts one year after the last menstrual period.

Premature menopause.

Premature menopause is considered to have occurred if a woman is younger than 40 years of age when she becomes menopausal.

Progesterone.

Progesterone is the natural hormone found in a woman's body that helps prepare the endometrium (lining of the uterus) for implantation of a fertilized egg.

Progestogen.

Progestogen is a hormone which can be natural or synthetic, but has the same effect on a woman's body as progesterone.

Progestin.

Progestin is a synthetic hormone which has the actions of progesterone.

Structure of the Thesis

The thesis structure reflects the qualitative methodology chosen to explore the research questions.

Chapter One provides an introduction to the research topic and outlines the context in which the research was undertaken. The core issues that underpin the research and the four research questions are presented.

Chapter Two reviews the literature considered pertinent to the research topic. This includes research in regard to the nature and onset of symptoms often associated with

perimenopause; an overview of the interventions and treatment options available for the management of symptoms and the respective research regarding the efficacy of particular interventions. In addition, research regarding the changing attitudes among women and health professionals towards treatment options will be presented as well as research concerning the impact of perimenopausal symptoms on women in the workplace. The limited literature on the effects of perimenopausal symptoms on women in leadership roles will also be presented. The literature reviewed includes the initial research that contributed to the formulation of the research questions and literature reviewed in response to the implications of the study findings.

Chapter Three outlines the methodology used in this study which includes a description of the recruitment of participants and the collection, interpretation and analysis of data.

Chapter Four outlines the findings of the study. This is presented as a narrative account of the experiences of the study participants, thereby honouring the richness of the data. The findings are presented as themes and emergent superordinate themes that represent the commonalities and differences within the reported experiences of the participants.

Chapter Five includes a discussion of the implications of the four superordinate themes and the relationship of the findings to the extant literature.

Chapter Six provides a brief overview of the study findings and discusses the implications of the findings in regard to further research and the development of effective interventions that may provide advice and support to perimenopausal women undertaking leadership roles.

Thesis Style and Referencing Format

The style of referencing and citation of sources applied in this thesis is consistent with that outlined in the 6th Edition of the Publication Manual of the American Psychological Association (APA, 2009). In addition to the introduction of technical

or key terms and labels (as specified by the APA), *italicised* typeface will also be used in this document to depict words and phrases quoted directly from the study participants' narrative.

Chapter Two: Literature Review

Introduction

In this chapter, the published literature pertaining to the nature and onset of perimenopausal symptoms, psychosocial and cultural issues and approaches to symptom management is reviewed. Research regarding the impact of perimenopausal symptoms on women in the workplace and in particular, women in leadership roles is also reviewed.

The Nature and Onset of Perimenopausal Symptoms

The majority of women will experience perimenopausal symptoms (Hickey et al., 2005; MacLennan, 2009) with an estimated 20% of those experiencing severe symptoms (Hickey et al., 2005). Although not all women have problems during perimenopause, some may experience symptoms they find distressing. The onset of perimenopause is often associated with clinical signs such as less regular menstrual cycles and vasomotor symptoms such as hot flushes and night sweats (Bradley, 2005). Most women will enter the period of perimenopause somewhere between 35 and 60 years of age (Greendale et al., 1999; Baldo et al., 2003; Baram, 2005; Cobia & Harper, 2005; Simon & Reape, 2009) with the average age at actual menopause of 51.4 years (Simon & Reape, 2009).

According to MacLennan (2009) perimenopausal symptoms may begin several years before the cessation of menstruation and may last well into old age. He divides symptoms into four main groups: vasomotor, including hot flushes and night sweats; psychological (e.g. irritability and anxiety); locomotor (e.g. joint pains and backache) and urogenital (e.g. urinary frequency and dry vagina). Other symptoms reported include sleep disruption, exhaustion, a crawling sensation under the skin, mood swings, depression and concentration difficulties (Baldo et al., 2003; Cutson & Meuleman, 2000; Eun-Ok Im, 2006; Smith & Michalka, 2003).

In addition to the symptoms associated with fluctuating hormones, the loss of ovarian function and subsequent decrease in oestrogen levels may have long-term consequences. These may include an increasing risk of cardiovascular disease, osteoporotic fractures, dementia and reduced cognitive function (MacLennan, 2009; Wren, 2009).

Although hormone levels become more stable as a woman enters postmenopause and many of the symptoms such as hot flushes and night sweats abate, the low levels of oestrogen may continue to have an effect on women's health and well-being for many years and even into old age (MacLennan, 2009). In addition, a number of symptoms such as certain urogenital problems may become more problematic in the years following menopause (Doyle, 2006).

Recognition of Symptoms

Although the majority of women will experience perimenopausal symptoms, research suggests that many women are not well informed about the age at which symptoms may begin or the nature of symptoms that may herald the onset of perimenopause (Baldo et al., 2003). Lyndaker and Hulton (2004) reported that “despite a proliferation of health education materials” (p. 340), many of the women (aged 30 to 50 years) in their study, failed to recognize symptoms they experienced as being associated with perimenopause.

Recognition of symptoms was also less likely, according to Boughton and Halliday (2008), when women entered perimenopause earlier than they or their health professionals expected. They found that the misdiagnoses of symptoms frequently caused the women in their study to experience a period of distress and uncertainty. In addition, study participants often thought they were imagining their symptoms or that they were losing their sanity. Boughton and Halliday also reported that health professionals frequently attributed symptoms that occurred outside the expected time frame for the onset of perimenopause, to a psychiatric basis. They say that this lack of recognition of symptoms may put some women (particularly those experiencing early

perimenopause) at a disadvantage in regard to seeking appropriate support and thus availing themselves of effective treatments.

Lyndaker and Hulton (2004) also say that health care providers need to be “better educated on the frequency and severity of perimenopausal symptoms and how these symptoms affect their clients” (p.341). They reported that the results of their study indicate that “education and anticipatory guidance should begin with women in their 30s” (p346). Furthermore they say that the “challenges of perimenopause justify further study, because the complaints of the women in perimenopause are real and must be taken seriously” (p346).

In addition to the lack of awareness regarding the nature and onset of perimenopausal symptoms, research indicates that there is often confusion regarding the terminology used to describe and define this time of a woman’s life. Pinkerton and Zion (2006) say that given the “biological and social significance of menopause, it is remarkable that the language used to describe this event and its associated symptoms is inconsistent” (p. 135). Similarly, Prior (2006) says that “ordinary women and official statements confuse and conflate perimenopause – the long, complex, life phase of higher and chaotic estrogen levels – with the low and stable estrogen levels of menopause” (p. 323). She says that the average woman uses the term menopause to refer to any changes experienced during midlife and into old age.

Another misconception, according to Prior (2006) is the belief that the period of perimenopause is associated with an oestrogen deficiency. Prior says that although hormones fluctuate at this time, oestrogen levels may actually rise during perimenopause, resulting in a range of symptoms including sore and often nodular breasts and mood swings. Perimenopause she says, begins in women with regular menstrual cycles who may begin to notice changes in the duration of cycles, breast tenderness, sleep disturbances and unusually heavy periods. She suggests that this lack of understanding may lead women to incorrectly assume that they are suffering from conditions such as fibromyalgia or chronic fatigue syndrome as a way of explaining the mood swings and low energy they may be experiencing. Reflecting on both her personal and professional experience of perimenopause, Prior suggests that the “lack of, or mis-information we as women receive deprives us of self-

knowledge, alienates us (further) from our bodies, and leaves us both diseased and dependent” (p. 327).

The attribution of unrecognised symptoms to other causes is also discussed by Twiss et al. (2007). They suggest that when women experience symptoms that are not usually associated with the menstrual cycle such as joint aches, they may attribute these to other conditions and this may lead to misdiagnosis.

Furthermore, according to Pinkerton and Zion (2006), in addition to the confusion about menopausal symptoms, women are also confused about symptom management and treatments. This confusion they say, makes it difficult for women to communicate effectively with the health professionals they consult. It is not surprising therefore that being well informed about symptoms and treatment options has been shown to result in an easier menopausal transition (Baldo et al., 2003).

Diagnosing Perimenopause

In regard to the diagnosis of perimenopause, the Australasian Menopause Society (AMS, 2008 a; AMS, 2010 d) recommends that doctors do not prescribe blood tests for hormone levels because they are unreliable at this time. They recommend that doctors counsel women about their clinical symptoms and provide advice about the risks and benefits of treatment options. They say that although menstrual cycles may become less regular prior to the final menstrual period which heralds actual menopause, this is not always the case. Many women may continue to have regular periods even though they are experiencing the fluctuating hormone levels associated with perimenopause. Furthermore they say that the symptoms experienced during perimenopause and prior to actual menopause may be the most distressing.

Minkin (2006) also discusses the problems associated with the diagnosis and management of perimenopause. She says that while the diagnosis of the menopausal patient is relatively straightforward because it is determined retrospectively following 12 months absence of menstruation, perimenopausal women may continue to have regular periods while experiencing symptoms of hormonal fluctuations. In addition

she says there is a false perception which is often promoted on daytime talk shows, that the menopausal transition is something that occurs overnight. The reality for many women she says is often a protracted process of hormonal fluctuations and the accompanying symptoms.

Symptoms Frequently Associated with Perimenopause

Vasomotor symptoms.

Among the most recognizable, disruptive and highly researched symptoms of perimenopause are the vasomotor symptoms such as hot flushes and night sweats. Although the cause of such symptoms has not yet been determined, Alexander and Moore (2007) propose that they are precipitated by a reaction in the brain to fluctuating hormone levels. These symptoms affect 70% to 85% of women (Baldo et al., 2003; Rymer & Morris, 2000) and according to Freeman et al. (2001) hot flushes are the main reason women in mid-life seek medical care.

Hot flushes are generally reported as a sudden sensation of warmth that may radiate outwards from a central point such as the chest. This sensation may last from seconds to an hour and is often accompanied by perspiration, tachycardia, anxiety, irritability, palpitations, breathlessness, a feeling of faintness, a rise in body temperature and even a sense of panic (Baldo et al., 2003; Cutson & Meuleman, 2000; Hickey et al., 2005; Reynolds, 1999). The severity of hot flushes increases with stress, fatigue and other stimuli such as high ambient temperatures, coffee and alcohol (Berendson, 2002; Cutson & Meuleman, 2000; Hunter, 2003). Night sweats may also be experienced by women having hot flushes but can arise independently (Hickey et al., 2005)

Politi, Schleinitz and Col (2008) say that the period of time in which hot flushes may be experienced is a median of 4 years. For many, hot flushes do not persist for more than about a year after the actual menopause, however, about a third of women may continue to have hot flushes for five years or longer (Hickey et al., 2005) with around 10% experiencing flushes 12 years after menopause (Crandall, 2008).

Sleep disruption.

According to Baber (2009) sleeplessness is twice as likely during perimenopause. Hudson (2004) attributes sleep disturbances in perimenopausal women to anxiety, vasomotor symptoms (night sweats) and the effect of hormonal changes on brain neurotransmitters. In addition to the disruption caused by night sweats, perimenopause may affect sleep quality in a number of ways including sleep-disordered breathing which is secondary to sleep apnoea and menopausal insomnia (Polo-Kantola, Saaresranta & Polo, 2001). According to Phillips et al. (2008), hormonal changes are strongly implicated in the doubling of the rate of obstructive sleep apnoea observed in post menopausal women.

In a study by Thurston, Blumenthal, Babyak & Sherwood (2006), self-reported data from women suggested that there is a relationship between hot flushes experienced at night as night sweats, sleep problems and subsequently, impairment of psychological functioning. They also found that more night-time hot flushes were detected by physiological monitoring than were reported by the women themselves. Other evidence for an association between changing hormonal levels and sleep disruption comes from studies of the effects of HRT on sleep quality. Phillips et al. (2008) reported that three cohort studies showed a reduction in the risk of sleep apnoea in postmenopausal women taking HRT. Pinkerton and Zion (2006) also cite the results of clinical trials that indicated a link between sleep quality and certain hormones. They reported that both sleep and quality of life were improved by the use of low-dose continuous combined oestradiol and norethisterone (progesterone). Similarly, Hudson (2004) says that oral HRT has been shown to decrease sleep disordered breathing, improve night-time restlessness and awakening and relieve vasomotor symptoms. She says that “women may experience sleep disturbance during the perimenopause transition and menopause itself, especially those who do not take hormone replacement therapy (HRT)” (p. 154).

Polo-Kantola et al. (2001) say that “severe sleep disturbances may lead to major impairment of daytime functioning and quality of life” (p.446). In addition, they say that the problem is often overlooked by both doctors and their patients. Mahoney (2005) also suggests that sleep problems can significantly diminish quality of life in

perimenopausal women and that this problem should not be overlooked. Furthermore, Arigo, Kloss, Kniele and Gilrain (2007) found an association between perimenopausal women's beliefs about the implications of having a disrupted night's sleep, anxiety and subsequent reduced quality of life.

Other research links reduced duration of sleep and disturbed sleep to a range of health and psychosocial issues. These include an increased risk of cardiovascular disease (Godfrey, Nagwa & El-Badri, 2009) and problems with cognition and depression (Hudson, 2004). A study by Blackwell et al. (2006) found that objectively measured disturbed sleep rather than total sleep time was consistently related to poorer cognition. Another study linked sleep deprivation with a decrease in night-time levels of the hormones ghrelin and leptin which regulate appetite and energy balance. The authors say the subsequent disruption in energy balance may explain prospective weight gain in insomnia sufferers (Motivala, Tomiyama, Ziegler, Khandrika & Irwin, 2009)

Urogenital symptoms and psychosexual problems.

Oestrogen maintains and supports the vaginal epithelium, maintains vaginal pH, enhances vaginal lubrication and prevents dyspareunia (painful intercourse) as well as playing a role in maintaining sexual receptivity (MacBride, Rhodes & Shuster, 2010; Rani, 2009).

According to MacBride et al. (2010), vulvovaginal atrophy (VVA) is a condition which is associated with falling oestrogen levels and characterised by a number of symptoms including vaginal dryness, soreness, stinging, spotting due to small tears in the thinning vaginal lining, urinary frequency and urge incontinence. Although this condition may occur at any time in a woman's life it is more prevalent in postmenopause, affecting between 30% and 50% of women (Doyle, 2006; MacBride et al., 2010). Furthermore, symptoms such as those affecting the reproductive system and the psychosexual effects of perimenopause may indirectly affect wellbeing and quality of life (Cobia & Harper, 2005).

The decline in vaginal blood flow and changes in vaginal pH due to the fall in oestrogen levels also predispose women to an increased likelihood of infections and inflammation (MacBride et al., 2010). Doyle (2006) says that in addition to the increased risk of fungal and bacterial infections, the urogenital atrophy that results from reduced oestrogen levels can also predispose women to incontinence. She suggests that these conditions all have the potential to impact on women's health and wellbeing and subsequently their work performance. Furthermore, unlike many of the other symptoms associated with perimenopause, vaginal symptoms, urinary frequency and stress incontinence may actually increase after menopause (Doyle, 2006).

It is significant according to Doyle (2006) that only 25% of women experiencing urogenital symptoms seek medical advice despite the prevalence of these symptoms. Many women, she says, simply assume such symptoms are an irreversible part of the ageing process. MacBride et al. (2010) also discuss women's reluctance to report urogenital symptoms. They say that women are more inclined to raise concerns about vaginal discharge and urinary frequency while being reluctant to report vaginal itching, soreness or pain on intercourse. They suggest that there may be a number of reasons why women do not report certain symptoms including embarrassment, the belief that such symptoms are unimportant or the fact that they may be treating the symptoms themselves.

Kingsberg (2009) also discusses issues associated with women's embarrassment about discussing certain urogenital symptoms. A number of studies are cited which indicate that embarrassment is a major obstacle for women particularly in regard to reporting issues associated with sexual function. In addition, according to Kingsberg, a survey found that 68% of women were concerned that they would cause their doctor to be embarrassed if they were to raise such issues. These concerns may have been well founded according to data cited by Kingsberg from a survey of almost 2000 health care professionals who admitted that their own embarrassment was an obstacle to their initiating any discussion about sexual health. According to Kingsberg (2009), issues associated with sexual dysfunction were unlikely to be discussed if it was left to the patient to raise the subject. She makes the following comment:

Lack of physician-patient communication is a major contributor to the under diagnosis of sexual dysfunction in women. Without proper recognition of these problems, women affected by FSD (female sexual dysfunction) remain untreated and experience adverse consequences that undermine their relationships and quality of life. (p. 524)

This issue is also discussed by Doyle (2006) who says that “with proper screening, detection and management of this condition, clinicians have an opportunity to positively affect the quality of life in this growing segment of the population” (p. 34).

Low libido is also an issue for women during perimenopause and in postmenopause according to MacLennan (2009). He suggests that a number of psychosocial factors including issues associated with the having elderly parents, adolescent children, problems with relationships and changes in body image, may contribute to waning libido. He suggests that sexual counselling and certain hormone therapies may be helpful for some women.

Although both oral and transdermal HRT can reduce many of the urogenital symptoms associated with peri and post-menopause, between 10% and 40% of women continue to experience urogenital symptoms and may benefit from the use of vaginal oestrogen preparations (Doyle, 2006; MacBride et al., 2010).

In regard to the use of HRT in the treatment of problems associated with sexual functioning or declining libido, Lovett (2003) says that transdermal HRT (skin patches) may be more effective in promoting orgasm than oral HRT. He explains that orally administered HRT first passes through the liver and this affects the levels of androgens and testosterone which subsequently affect the woman’s sexual response.

Unusually heavy or irregular periods.

Changes in the duration and frequency of the menstrual cycle occur in approximately half of all women by the age of 45.5 years and in 95% of women by the age of 50.8 years (Bradley, 2005). Heavy or irregular periods around the time of perimenopause may be associated with fluctuating hormonal levels and alternating ovulatory and anovulatory cycles according to Hale, Manconi, Luscombe and Fraser (2009).

Around 70% of perimenopausal women will have lower than usual menstrual flow at around this time; 12% a sudden cessation of menstruation and about 18% an increase in the flow and frequency of menstruation (Bradley, 2005). Garside, Britten and Stein (2008) found that women frequently reported a range of concerns associated with irregular or heavy periods. These included concerns about spotting and a subsequent reluctance to socialise or wear certain clothing at this time.

A further consequence of prolonged episodes of heavy or frequent menstruation may be anaemia due to the increased blood loss (Garside et al., 2008). This may in turn cause cardiovascular problems, fatigue and loss of stamina, impaired cognitive function and sexual dysfunction as well as a reduction in the woman's overall quality of life (Szromba, 2009).

Irritability, anxiety, low mood and depression.

The relationship between the hormonal changes associated with perimenopause and depression remains controversial. Although the AMS (2008 b) says that moderate to severe depression is no more common at menopause than at any other time, they concede that hormonal changes may contribute to moodiness.

A number of researchers are however, more confident about the link between hormonal changes, low mood and depression. Soares (2003) states that research data strongly suggests an increased risk of depression in perimenopausal women and a relationship between hot flushes and depression even in women with no prior history of depression. Similarly, Cobia and Harper (2005) cite numerous studies that indicate

a relationship between changing endocrine function during perimenopause and both major and minor depression. They also say that the cause of perimenopausal depression is different from depression experienced in other circumstances and may also differ in both presentation and response to treatment.

Miller (2006) says that studies indicate an increase in depressive symptoms in perimenopausal women with one longitudinal study reportedly showing perimenopausal women at a significantly greater risk of clinical depression than those who had not yet entered this life stage.

Soares and Almeida (2001) reported a prevalence rate of 49.5% of psychiatric morbidity among endocrinologically confirmed perimenopausal women (aged 40-58 years). In a later study Soares and Zitek (2008) say that the fluctuating oestrogen levels during the menopausal transition can often precipitate symptoms of anxiety and depression. This period they say constitutes a period of vulnerability and time of increased risk of developing mood disturbances and depression. Furthermore they say that there is recent evidence that women face an increased risk of developing depressive symptoms during times of fluctuating reproductive hormones such as premenstrually, during and after pregnancy and during the menopausal transition. They suggest that emotional and physical changes associated with perimenopause and early postmenopause, could lead to a “significantly impaired functioning and poorer quality of life” (p.336).

Much of the evidence for a link between hormonal fluctuations and mood is derived from studies of the effects of HRT. Morrison and Tweedy (2000) cite a number of studies suggesting that HRT and in particular oestrogen, may improve some aspects of psychological and cognitive function with the exception of major depression. Another researcher, Miller (2002), found that 68% of study participants who were given oestrogen replacement therapy (ERT) had a remission of their depression.

Although Stephens, Pachana and Bristow (2006) say that the research regarding the relationship between oestrogen and mood is equivocal, they claim that the use of HRT in non-depressed women has been associated with an improvement in mood. Cutson and Meuleman (2000) also say that oestrogen therapy improves mood and

dysphoria, and suggest this may be mediated through its effect on the metabolism of serotonin in the central nervous system.

Further evidence for a link between perimenopause and depression is provided by Oishi, Mochizuki, Otsu and Inaba (2007) who also assert that the serotonergic system is involved in perimenopause and that serotonin levels are lower in women postmenopause than in those who have not yet entered perimenopause.

Robinson (2001) looked at mood disorders and psychiatric illness during perimenopause. The role of oestrogen and progesterone in regulating mood, and cognitive function and the possible role of oestrogen in protecting against the development of schizophrenia was discussed. According to Robinson:

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The Domino Theory postulates that low mood, irritability and decreased concentration may occur as a result of the hormone-sensitive physical complaints that often accompany menopause. Sleep disturbances secondary to night sweats, and irritability, discomfort and decreased self-esteem due to hot flashes, may lead to psychological symptoms that can be confused with major depressive disorders. (p. 178)

In addition, Robinson (2001) cites an earlier study by Jaszmann, Van Lith and Zatt (1969) which she describes as comprehensive. This study included 3000 women aged 40 to 60 years and found that “complaints of mental imbalance, fatigue, depression and irritability were most common in women who were still menstruating, reaching a peak in women who could be considered immediately premenopausal” (p. 177).

In another study, Ryan, Carriere, Scali, Ritchie & Ancelin (2008) investigated whether there was a link between lifetime hormonal factors and depression in later life. They found that an earlier age at menopause was associated with a greater risk of depression in later life, but only for those women with a lower level of education. A number of factors were postulated to contribute to discrepancies associated with the

relationship between hormonal exposure and depression including the route of administration of exogenous oestrogen (patches versus pills). They concluded that there should be further investigation to determine which hormonal interventions may be used to treat certain sub-groups of women for late-life depression.

Changes in cognitive function.

Of particular relevance to women undertaking cognitively demanding work (such as leadership roles) is the postulated relationship between oestrogen and aspects of cognitive function. For example, according to Dohanich (2003), research shows that oestrogen and progesterone influence the electrical, biochemical and structural properties of brain neurons involved in learning and memory. Similarly, Cutter, Norbury and Murphy (2003) say that research indicates that oestrogen affects brain function in a number of ways including brain ageing, glucose metabolism and aspects of neurotransmitter function. Furthermore, Lebrun et al. (2005) say that study findings indicate that endogenous oestrogens may have a protective effect against the cognitive decline usually associated with ageing.

Changes in cognitive function observed following the initiation of hormone therapy offer further insight into the relationship between oestrogen and cognition according to a number of researchers. For example, Tierney (2000) suggest that for women with low blood serum levels of oestrogens, taking even low doses of the hormone may have cognitive-enhancing effects. Similarly, Hogervorst, Yaffe, Richards and Huppert (2006) consider it biologically plausible that cognitive decline in postmenopausal women may be avoided by maintaining high levels of oestrogen. This hypothesis gains further support with Lokken and Ferraro's (2006) study in which they found that postmenopausal women using HRT significantly outperformed postmenopausal women who were not using HRT on a number of tests designed to evaluate aspects of cognition.

Similarly, Miller, Conney, Rasgon, Fairbanks and Small (2002), claim that the postmenopausal use of oestrogen is associated with improvement in mood and performance on tasks of fluency and working memory. A study by Stephens et al.

(2006) also indicated that oestrogen may enhance verbal memory in women between the ages of 40 and 60. More recently, Greendale et al. (2009) cite the Study of Women's Health Across the Nation (SWAN) which assessed a number of aspects of cognitive functioning in a group of 2,362 women over several years. The study found that the problems with memory and cognition that develop during perimenopause may be more annoying than disabling and appear to resolve once women reach menopause.

According to Greendale et al. (2009) women often experienced a decrease in cognitive performance during perimenopause at which time they were not able to learn as well as they had in premenopause. This decrement disappeared in postmenopause suggesting a time-limited effect. They also found that while initiating HRT prior to the final menstrual period had beneficial effects on cognitive function, initiation of treatment at a later time had a detrimental effect. In particular they found that scores of verbal memory and processing speed increased during early perimenopause but levelled out or declined during late perimenopause.

There continues to be wide debate about the relationship between oestrogen, mood and cognitive function. For example, Henderson and Sherwin (2007), suggest that further research is needed to determine the efficacy of oestrogen therapy in improving cognitive function.

Regardless of the controversy surrounding this issue, Greendale et al. (2009) say that around 60% of women report problems with learning and memory during perimenopause. Luetters et al. (2007) while also acknowledging that around 60% of perimenopausal women perceive that they have memory problems, claim to have found no association between menopause transition and various tests of cognitive performance. These claims are challenged by Stephens et al. (2006) who suggest that a number of studies which found equivocal or no effects of exogenous oestrogen were focussed on older women. They suggest that exogenous oestrogen may enhance verbal memory in younger mid-life women (40 to 60 years of age) while having little effect in older women.

The differential between the effects of HRT on younger versus older women is referred to as the “critical window hypothesis” by MacLennan (2009, p.120). He explains that although HRT undertaken at, or close to the time of menopause, has been shown in observational studies to produce cognitive benefit, hormone therapy does not reverse cognitive decline in older women who may already have cognitive deficits prior to undertaking HRT.

Sherwin and Henry (2008) also discuss the critical period hypothesis, postulating a number of possible factors that may contribute to the different cognitive effects of oestrogen when administered to older versus younger women. They suggest that brain ageing, which may include a number of factors such as a decrease in brain volume, neuronal size, neurotransmitter system changes and a reduction in dendritic spine numbers may inhibit any possible neuroprotective effects of exogenous oestrogen on the brain. They also suggest that the route of administration and type of HRT may be a factor.

A study by Ryan et al. (2009) also investigated the relationship between hormone therapy, cognition and dementia while focusing on the type of therapy, time of initiation of treatment and duration of treatment. They concluded that although current hormone therapy was associated with better performance in certain areas of cognitive function, this association was dependent of the duration and type of treatment used. They also reported that they did not find evidence of a critical period for initiation of HRT saying that therapy did not need to be started close to menopause to benefit cognitive function in later life.

In addition to investigating the effects of HRT on cognitive function, a study which also investigated the benefits of physical activity in older women, found that cognitive performance was enhanced in physically active older women using HRT. The researchers also found however, that physical activity improved cognitive function irrespective of HRT use (Etnier & Sibley, 2004).

Finally, in addition to possible changes to cognitive function and mood, mild forms of psychosis during perimenopause are relatively frequent according to Huber et al. (1999). This association between hormonal changes and mental health is supported by

Robinson (2001) who suggests that it is the loss of the protective effects of oestrogen that may be related to the slight increase in the incidence of schizophrenia in women around the time of menopause.

Other Consequences of Reduced Oestrogen Levels

Although the changing hormonal levels experienced during peri and postmenopause are often associated with symptoms that may or may not be recognised by the woman herself, there are other long-term consequences associated with diminished oestrogen levels. These include an increased risk of cardiovascular disease, osteoporotic fractures, diminished cognitive function and dementia that may not initially produce symptoms (MacLennan, 2009).

Cardiovascular disease.

According to Wren (2009), women experience less cardiovascular disease than their male peers and this protection continues until around 10 years after menopause due, it is thought, to the residual protective effects of oestrogen on the cardiovascular system. Wren says that clinical studies indicate that when HRT is initiated within a few years of menopause women continue to have between 40% and 60% less risk of hypertension and myocardial ischaemia although he says there is a two to three fold increase in the risk of thromboembolism.

Dementia.

According to Godfrey, Nagwa and El-Badri (2009) dementia is the fifth leading cause of death among women and among the most feared of diseases. They say that the lifetime risk of developing dementia is one in seven for men and one in five for women. Although a number of factors are implicated in the development of dementia, the authors say that the role of oestrogen in delaying the onset of dementia may be associated with the demonstrated, potent antioxidant effects of oestrogen on the

mitochondria. They say that for perimenopausal women who are able to use HRT, there may be a positive effect on mild to moderate dementia.

An earlier but comprehensive long-term study which was conducted over 22 years and involved almost 9000 women (the Leisure World cohort), found that oestrogen users had a significantly reduced risk of Alzheimer's disease and related dementia compared to nonusers and there was a significant reduction in the level of that risk with both increased dose and duration of use (Paganini-Hill & Henderson, 1996). Birge (2002) as cited in Meisler (2002) says that there is strong data suggesting that oestrogen, when given in perimenopause can delay the onset of Alzheimer's disease by 50% to 60%.

Furthermore, according to Wren (2009), the relationship between the age at which hormone therapy is commenced and the efficacy of such treatment was also relevant in regard to the management of dementia. He says that the women in the WHI study group were all over 65 years of age when they entered the study and appeared to have little benefit and even an increased risk of developing dementia when HRT was commenced at this late stage. He says that clinical studies have shown that beginning oestrogen therapy at or soon after menopause actually reduces the risk of dementia.

Osteoporosis.

Falling oestrogen levels during perimenopause and following menopause change the normal regulation of bone mass, resulting in an increase in the rate of bone loss (Vibert, Kompis & Hausler, 2003; Wren, 2009). This may result in osteopenia which is characterised by a sub-normally mineralised bone and subsequently, osteoporosis which is associated with weakened bones that fracture easily (AMS, 2010 c).

According to the AMS, the average woman loses up to 10% of bone mass during the first five years following menopause. In addition, they say that about half of all women over 60 years of age will have at least one fracture as a result of osteoporosis.

Lifestyle factors such as undertaking weight-bearing exercise, avoidance of smoking and excessive alcohol and the use of calcium and vitamin D3 supplements can reduce

bone loss and improve bone health (AMS, 2010 c; Godfrey, Clifford & Rosen, 2008). For women at risk of, or with diagnosed osteoporosis however, HRT was the preferred treatment prior to the release of the WHI findings (Canderelli, Leccesse & Miller, 2007). Although HRT continues to be prescribed when considered appropriate, other treatment options are now being promoted for postmenopausal women to reduce their risk of osteoporosis. These include a class of drugs called biphosphonates, as well as selective oestrogen receptor modulators (SERMS) and tibolone which have been shown to be at least as effective as HRT in preventing osteoporosis. As with the use of HRT however, these drugs may also have risks and side-effects in some women (Canderelli et al., 2007).

Changes in metabolism and weight gain.

Although studies of midlife women consistently show an increase in body weight, it is unclear whether this is related to ageing or the hormonal changes associated with perimenopause (Lovejoy, 2009). Lovejoy says however, that studies do indicate that there is a change in body composition around menopause with menopausal women having lower lean body mass and higher fat mass. In addition, Lovejoy says there is an increase in abdominal fat distribution which has been associated with an increased risk of metabolic diseases such as diabetes as well as an increased cardiovascular risk. Furthermore Lovejoy says, studies indicate that post-menopausal women using HRT have less abdominal fat.

Psychosocial, Ethnic and Cultural Issues

Current research into the psychosocial impact of perimenopause on women is scant. A number of earlier studies focussed on issues including the medicalisation of menopause (Huffman & Myers, 1999) and reproductive life stages (including menopause) to the exclusion of social and psychological factors which were considered to play an equally significant role in women's experience of midlife (Lippert, 1997).

McKee and Warber (2005) cite Hunter (1993) who showed that multiple psychosocial factors including physical health, social situation, stressful life events and beliefs about menopause, may predict a menopausal woman's reported quality of life. Similarly, Dennerstein, Lehert and Guthrie (2002) reported changes in women's well-being during the menopausal transition. They found that negative mood declined and women's well-being improved as they entered the later stages of the menopausal transition and that a number of psychosocial factors including marital status, work satisfaction and number of concerns and adverse life events also had a significant effect. Furthermore they say that because the bodily changes associated with menopause are intrinsically linked to gender and reproduction, the experience of symptoms is "inevitably imbued with social and cultural meanings concerning what it is to be female, to be an older woman" (p. 191). Binfa et al. (2004) also found that psychosocial factors affect menopausal symptoms and identified a link between the intensity of symptoms, biological predisposition and a history of premenstrual syndrome.

Li, Holm, Gulanick and Lanuza (2000) investigated the changes in the quality of life (QOL) ratings of women during perimenopause. They found that psychosomatic complaints were more frequently reported than vasomotor complaints (such as hot flushes) and were more positively related to QOL indicators. They concluded that managing psychosomatic symptoms may be important to improving QOL for women during the perimenopausal period. Gita and Kuh (2006) also reported that a number of factors affect women's quality of life during the menopausal transition. They concluded that although the experience for most women is complex, it is not necessarily "overwhelmingly negative" (p. 93).

A number of comprehensive studies have provided information regarding the psychosocial factors associated with women's experience of perimenopause. An example is the Study of Women's Health Across the Nation (SWAN) which was initiated in 1994 and had over 3000 mid-life women enrolled across the United States. Data gathered during this study provided Santoro (2004) with information in regard to the impact of ethnicity, culture and socioeconomic status on menopausal women. She found that although ethnicity was strongly related to the experience of symptoms and the health status of women, socioeconomic status was a confounding factor because

the representatives of different ethnic groups were selected from communities with varying socioeconomic circumstances. The study provided support for the findings of other smaller studies which indicated that smoking, socio-economic status and racial/ethnic factors influence the age at which women reach actual menopause and the way in which they experience symptoms.

Anderson, Yoshizawa, Gollschewski, Atogami and Courtney (2004) compared the midlife experiences of Australian and Japanese women. They found that the experience of menopause was different for each group. The Australian women reported significantly more vasomotor symptoms such as sleeplessness and night sweats while the Japanese women reported more psychological and somatic symptoms including nervousness, panic attacks, difficulty concentrating and feeling unhappy or depressed.

Hunter (2003) suggest that “menopause is very much associated with negative beliefs and images in western societies, and concerns about hot flushes representing visible signs of menopause can be distressing if these beliefs are taken on board” (p. 189). The concept that it may be women’s interpretation of the physical symptoms of menopause, in particular those related to vasomotor symptoms such as palpitations that may exacerbate their experience is discussed. Hunter suggests that this negative perception of symptoms may result in feelings of anxiety, irritation, low mood or embarrassment.

More recently, a study by Marvan, Islas, Vela, Chrisler and Warren (2008) looked at the stereotyping of women at various stages of their reproductive lives. They say that in the majority of Western cultures, women do not look forward to menopause. They cite a number of studies that suggest that women fear a loss of status as well as physical attractiveness at this time. Their study of women in Mexico and the United States found that survey respondents stereotyped menopausal women as irritable and moody and used the term “old” to define menopausal women. They suggest, however, that this is not always the case, with women in some Asian countries reportedly having a more positive view of menopause.

Finally, according to Boughton and Halliday (2008), women experiencing premature menopause (before age 40 years) encounter particular psychosocial problems. Their study (as reported earlier) found that participants were distressed when, on many occasions, the health professionals from whom they sought a diagnosis and explanation for particular symptoms, were inclined to discount the possibility of perimenopause based on the woman's young age. This reportedly resulted in a tendency for symptoms to be attributed to psychological rather than physiological factors and the women consequently experienced the stigma often associated with this type of diagnosis.

Treatments and Management of Perimenopausal Symptoms

Complementary and alternative medicines (CAMs) and other alternative therapies.

A report by MacLennan et al. (2002) found that "alternative" or "natural" therapies for hot flushes were used by 52% of Australian women with an estimated expenditure of \$2.3 billion per year. According to a more recent report by MacLennan (2009) around 60% of women self-medicate or seek alternative therapies to relieve their symptoms and 20 to 30% of women between the ages of 50 and 60 use HRT.

Although non-pharmacological treatments such as acupuncture and behavioural interventions may offer some benefits (Hickey et al., 2005; McKee & Warber, 2005), Hickey et al. (2005) say that there is a paucity of clinical research data available to confirm this. MacLennan (2009) says that it is "very important to differentiate the common temporary placebo effects of most unproven therapies for menopausal symptoms from the prolonged and statistically and clinically better results of truly effective therapies" (p. 114). Furthermore, MacLennan reports that a systematic Cochrane review indicated a placebo effect of 58% for hot flushes and night sweats compared to a 90% effect with combined (oestrogen plus progesterone) HRT.

Some of the treatments for which there continues to be inconclusive evidence regarding efficacy and safety include vitamin E, black cohosh, liquorice root and the

use of naturally occurring plant hormones or phytoestrogens (Cutson & Meuleman, 2000; Hickey et al., 2005; Hunter, 2003; MacLennan 2009).

Other non-pharmacological treatments and interventions have been shown to have a positive affect on the health of perimenopausal women. For example, MacLennan (2009) says that, in regard to reducing the risk of osteoporotic fractures, an increased calcium intake and vitamin D supplements (when necessary) may assist in slowing bone loss and thus reduce the risk of osteoporotic fractures. In addition, he says that exercise has been shown to reduce the risk of osteoporotic fractures by improving balance and slowing postmenopausal bone loss as well as reducing the number and intensity of hot flushes and improving women's quality of life.

The so called "bioidentical" hormones that are compounded by pharmacists are promoted as a more natural alternative to conventional HRT. According to Eden, Hacker and Fortune (2007), these products typically contain three oestrogens (oestrone, oestradiol and oestriol), progesterone and androgens such as testosterone and DHEA. They are usually provided as creams or as troches (tablets or capsules) in doses supposedly tailored to individual requirements. It is a concern according to Eden et al., that these products are not regulated by the Therapeutic Goods Administration and there is no evidence of safety or efficacy. This lack of regulation has recently prompted the AMA to request that such products be subject to similar safety warnings as those applied to other pharmaceutical products (Hickey, 2009).

In addition to criticism regarding the lack of regulation, MacLennan (2009) says that "claims that testing a woman's saliva to 'tailor' such products are completely unsubstantiated, are pseudoscience and lead to inappropriate prescriptions" (p.115). He makes the following comment regarding the promotion of certain products and therapies:

It is morally wrong and scientifically and medically unsound to advocate and purvey therapies that at best only have a placebo effect. This policy will eventually cause the distrust in the doctor-patient relationship, may lead to unexpected or unrecognised side-effects, will delay the use of effective

therapies, exploit the gullible, waste the health dollar and will not have long-term benefits. (p.121)

Evidence based therapies.

Non-hormonal therapies.

In addition to hormone-based therapies which may include preparations containing oestrogen, progestins and other hormones such as testosterone in various combinations, there are a number of other pharmaceutical medicines that are used to treat certain perimenopausal symptoms. For example, according to Speroff, Gass, Constantine and Olivier (2008), desvenlafaxine which is a serotonin-norepinephrine reuptake inhibitor significantly reduces the number and severity of hot flushes in postmenopausal women.

The effectiveness of such medications is questioned however by MacLennan (2009) who says that a number of pharmaceutical medicines including selective serotonin or noradrenaline re-uptake inhibitors (SSRIs) which are primarily used for treating depression are only marginally more effective than placebo in reducing the severity and frequency of vasomotor symptoms. In addition, there are a number of side-effects reportedly associated with the use of SSRIs include sexual dysfunction (Baldwin, Hutchinson, Donaldson, Shaw and Smithers, 2008) and an increase risk of bone loss and subsequently, osteoporotic fractures (Rosen, 2009; Saag, 2007). Furthermore, in regard to the use of serotonergic antidepressants, McIntyre et al. (2005) found that following the release of the WHI report in 2002, “a significant decrease in the number of HRT prescriptions was associated with a statistically significant increase in prescriptions of serotonergic antidepressants “(p.57). They suggest that this indicates that antidepressants are being prescribed for the management of both psychological and physical symptoms of perimenopause which were previously more commonly controlled with the use of HRT.

Other products including clonidine and gabapentin also have a slightly better than placebo effect on vasomotor symptoms according to MacLennan (2009) but may also have side-effects that could reduce long-term compliance. Other compounds including selective oestrogen receptor modulators (SERMS) have been used to either mimic or block the action of oestrogen in different tissues. These compounds include Tamoxifen which is used as an adjuvant treatment for oestrogen-receptor positive breast cancers and Raloxifene which is used to manage postmenopausal osteoporosis (AMS, 2010 c; Davis, 2003)

Hormonal therapies (HRT or HT).

The terms hormone replacement therapy (HRT) or hormone therapy (HT) refer to the treatments used to manage the symptoms associated with peri-menopause, and post-menopause and the long-term consequences of oestrogen deficiency (AMS, 2010 b; MacLennan, 2009). Therapies are available in both oral and transdermal preparations and include oestrogens only; oestrogens plus progestogen or combinations of hormones including oestrogen, progestogens and testosterone. Tibolone is another form of hormone therapy used for treating menopausal symptoms such as hot flushes, vaginal dryness and bone loss (MacLennan, 2009). According to Hickey et al. (2005), tibolone “is a synthetic prohormone with weak oestrogenic, progestagenic, and androgenic actions” (p. 414). This androgenic effect they say, may improve sexual function in some women but may also have an unfavourable effect on HDL cholesterol and triglycerides.

HRT has been used for the past 70 years to relieve a number of perimenopausal symptoms and improve the quality of life for menopausal women (Wren, 2009). In addition, Wren says that HRT’s effectiveness in treating the symptoms associated with fluctuating oestrogen levels is well documented. Wolfman (2005) says HRT is more than 85% effective in treating vasomotor symptoms such as hot flushes and Hickey et al. (2005) say that HRT reduces vasomotor symptoms in perimenopausal and postmenopausal women by 90% and 65% respectively. According to Baber et al. (2003), Cochrane reviews of published randomised controlled trials have clearly established the evidence for the efficacy of HRT.

The Risks and Benefits of HRT

There have been a number of long-term placebo controlled, randomised controlled trials such as the Women's Health Initiative (WHI) and the Women's International Study of long Duration Oestrogen after Menopause (WISDOM) that have included research into the risks and benefits of HRT use. Some studies such as The Nurses Health Study have continued for almost 30 years (MacLennan, 2009).

According to Wren (2009), concerns about the long-term safety of HRT resulted in the initiation of the WHI study which was intended to run for over eight years but was stopped after five years. This early termination he says, was due to statistically non-significant increases in the incidence of breast cancer and statistically significant increases in myocardial infarction, thromboembolism and stroke among study participants. Similarly, another large cohort study, The Million Women Study, which was undertaken in the United Kingdom and published in 2003 also found that HRT increased the breast cancer risk in study participants (Wren, 2009). According to Wren, not all the WHI results however, indicated an increase in negative outcomes with HRT use. Wren says that the study also found that there were statistically significant reductions in hip fractures and colorectal cancers.

More recent analysis of the new data from a number of studies including WHI has changed the risk:benefit ratio for the majority of women who begin HRT close to actual menopause (MacLennan, 2009). In 2004, the results of the second arm of the WHI trials were published. These results showed that women receiving oestrogen without progestogen had a reduction in the incidence of breast cancer, osteoporosis related fractures, stroke and myocardial infarction (MacLennan, 2009; Wren, 2009). These findings suggest that progestogens may play a role in the increased incidence of breast cancers in women using HRT which contains both oestrogen and progestogens (MacLennan, 2009). The results also found benefits associated with HRT use for women less than 60 years of age (Holloway, 2009).

The critical therapeutic window hypothesis that has been suggested in regard to the effects of HRT on cognitive function may also apply to the cardioprotective effects of oestrogen (MacLennan, 2009). According to MacLennan, the benefits of HRT on the

cardiovascular system appear to be dependent on the continued responsiveness of vascular oestrogen receptors to exogenous oestrogen. He says that when administered around menopause, HRT appears to reduce the progression of atherosclerotic plaques although existing plaques may actually be disrupted when HRT is administered many years after menopause, often with adverse effects.

According to MacLennan (2009) and Wren (2009) neither the WHI nor the WISDOM trials studied women who represented the normal users of HRT. Both say that the majority of study participants were women who had commenced HRT up to 14 or 15 years after menopause. They also say that many had pre-existing health problems including hypertension, diabetes and elevated cholesterol. In addition, 50% of participants were past or current smokers; 34% were obese and 35% were overweight (Wren, 2009).

Carroll (2008) also highlights discrepancies within the WHI study in regard to the age of the study participants. She says that recent sub-analyses and pooled meta-analyses of the findings of the WHI trials supports the premise that initiation of therapy between the ages of 50 and 59 puts women at a lower risk of cardiovascular events than those initiating therapy several years postmenopause. Carroll reports that compared with the placebo group, the number of women in the 50 to 59 age group experiencing cardiovascular events subsequent to using HRT was in the range of zero to one additional case per 1000 women per year of hormone use. This she say, defines such events as rare.

According to MacLennan (2009), hormone therapies are the most effective and best researched interventions for the management of both menopausal symptoms and the longer-term consequences of oestrogen deficiency. He says that Cochrane systematic reviews show HRT's effectiveness in reducing vasomotor symptoms and urogenital symptoms such as vaginal dryness and painful intercourse. In addition, he says that both the WHI and WISDOM studies showed a significant reduction in sleeplessness and joint pain as well as an improved sexuality and overall health-related quality of life with the use of HRT.

Other benefits of HRT include the prevention of fractures associated with osteoporosis which is both cost-effective and relatively safe according to MacLennan (2009), if initiated in osteoporotic women before the age of 60 years. Furthermore, MacLennan says that combined HRT has also been shown to be associated with a small decrease in bowel and uterine cancers and (as mentioned earlier) a cognitive benefit when initiated close to menopause. He maintains that the use of appropriate hormone therapies does not increase the risk of any major disease in women who commence therapy close to the time of menopause and continue therapy for up to five years.

Wren (2009) also discusses the benefits of oestrogen. He states that “when begun within 5 years of menopause in healthy women, oestrogen-based HRT results in far greater benefits than adverse outcomes” (p. 321). He says that there is substantial objective evidence for the benefits of HRT which include reducing distressing menopausal symptoms, risk of osteoporotic fractures, dementia and colorectal cancers. In addition, he says HRT improves wellbeing and quality of life as well as improving aspects of urogenital health and subsequent sexual enjoyment, maintaining cardiovascular health and increasing longevity. Adverse effects he says include a doubling of the risk of thromboembolism with oral HRT and promotion of the growth of pre-existing breast tumours.

Another study (Paganini-Hill et al., 2006 as cited in Wren, 2009) looked at data from the Leisure World cohort study which was conducted over 22 years and involved 8801 women. Findings indicated that those women who commenced using HRT at menopause and continued for the remainder of their lives, had fewer adverse events and lived longer than women who did not use HRT.

As discussed earlier, other research indicates the benefits of HRT for improving mood in perimenopausal women. Robinson (2001) discusses the benefits for women with mild or no depressive symptomology in using physiological doses of oestrogen (p. 180). Ancelin, Scali and Richie (2007) report that 69% of experts recommended HT (HRT) as the first-line therapy for “first episodes of mild and moderate depression occurring at perimenopause, with antidepressants being recommended as the second option” (p. 481).

Similarly, Miller (2002) cites Soares et al. (2001) that transdermal ERT (estrogen replacement therapy) is an effective antidepressive treatment in perimenopausal women with depressive disorders. In addition, McIntyre et al. (2005) say that although the mechanism by which oestrogen might attenuate depressive symptoms is unknown there are a number of reports of the “putative antidepressant effects of HRT” (p.57). In addition, Kotz, Alexander and Dennerstein (2006) also reported on studies which found that oestrogen improved general well-being in some groups of surgically menopausal women.

Canderelli et al. (2007) provide an overview of the current research on the use of HRT. They conclude that in addition to alleviating certain perimenopausal symptoms, HRT, when used in the first five years following menopause, may be useful in preventing some comorbid conditions including type II diabetes, cardiovascular disease, osteoporosis and colorectal cancer.

In 2007, citing what they considered to be incorrectly extrapolated data from the WHI studies, the International Menopause Society called for a revision of the current guidelines on prescribing HRT. They said that the safety profile for the use of HRT for women up until the age of 60 years is favourable and should not preclude women from using HRT when considered appropriate (Pines et al., 2007).

MacLennan (2009) makes the following comment regarding the changing guidelines regarding the use of HRT and subsequent risks and benefits:

Recent analysis of new data from WHI, other RCTs and observational and animal studies have now unified much of the HRT data, changed the risk: benefit ratio for the large majority of women who commence HRT for symptom control around menopause and given cause for the guidelines to be reviewed and changed. (p. 121)

Recently, the North American Menopause Society (NAMS, 2010) published their *Position Statement* on the use of oestrogen and progestogen in postmenopausal women. They provided the following statement:

Recent data support the initiation of HT around the time of menopause to treat menopause-related symptoms; to treat or reduce the risk of certain disorders, such as osteoporosis or fractures in select postmenopausal women; or both. The benefits-risk ratio for menopausal HT is favourable for women who initiate HT close to menopause but decreases in older women and with time since menopause in previously untreated women (p. 242).

Several smaller studies also indicate that HRT has benefits for a range of conditions that are associated with low oestrogen levels. For example, Hederstierna, Hultcrantz, Collins and Rosenhall (2007) found that postmenopausal women who were using HRT had better hearing than those who were not and Cook, Bass and Black (2007) found that active women using HRT had less tendon abnormalities than non-users.

Finally, there are issues regarding the routes of delivery of hormone therapy in regard to the safety and efficacy of such treatments. Carroll (2008) discusses the risks and benefits of transdermal HRT as compared to oral therapy. She says that in Europe, transdermal oestrogen therapy has been the dominant prescribing practice for decades. In contrast, oral oestrogen therapy is the most commonly prescribed in the United States. Of particular significance according to Carroll is the need for oral oestrogen to be administered in supraphysiological levels to achieve therapeutic levels of circulating hormone. She says that between 60% and 90% of oral oestrogen is metabolised in the liver while transdermal oestradiol avoids this and achieves more consistent blood oestrogen levels. Furthermore, she says that oral oestrogens are more likely than transdermal to cause side-effects such as sore breasts and break-through bleeding which is often associated with the discontinuation of therapy.

Changing Attitudes to the Treatments and Management of Perimenopausal Symptoms

Despite the evidence for the efficacy of HRT, the confidence in this treatment previously enjoyed by many women (and their doctors) was reportedly compromised by the release in July 2002 of the findings of the Women's Health Initiative (WHI) study (Heinemann et al., 2008; Hickey et al., 2005; Kauffman, Castracane & van Hook, 2005; MacLennan 2009; Simon & Reape 2009; Wren, 2009).

According to Wren (2009), the release of the WHI report which indicated adverse effects associated with the combined oestrogen and progestin trial, had a dramatic negative effect on the prescribing habits of health professionals. Wren says that "because of these negative findings, many health professionals stopped prescribing oestrogen-based hormonal therapy, and women were bewildered by the conflicting information regarding the safety of HRT" (p. 321). Similarly, Simon and Reape (2009) say that following the negative publicity associated with the WHI report, many women now avoid pharmacological treatments preferring to either put up with symptoms or try unregulated alternative therapies. Holloway (2009) also says that these negative findings led to an increase in confusion amongst women, the media and the medical professionals who have subsequently become more reluctant to prescribe HRT.

Several studies show the extent of the fall in HRT use following the negative publicity regarding HRT. In Australia, a study conducted by MacLennan et al. (2004), found that subsequent to the publication of the WHI report there was a two thirds drop in HRT use within the authors' study population. Similarly, Hickey et al. (2005) investigated the attitudes of doctors and their patients to HRT and found that a substantial number of Australian women had stopped using HRT following the release of the WHI report, because of their concerns about side-effects. In the year 2000, 38.8% of Australian women in their fifties were using registered conventional HRT according to MacLennan, Gill, Broadbent and Taylor (2009). The level of use declined to 11.8% in 2008 with another 4% using non-registered hormonal products.

Kauffman et al. (2005) suggest that there is now “an atmosphere of unease and trepidation” (p. 592) around the issue of HRT use. He says that “widespread concern over safety issues persists among many physicians and menopausal women despite the fact that estrogen therapy is unparalleled in the treatment of such symptoms” (p. 592). Furthermore, according to MacLennan (2009, September) misinterpretation of the WHI findings resulted in misinformation and a degree of hysteria that has subsequently placed symptomatic perimenopausal women at a disadvantage.

A number of authors refer to the role of the media in promulgating and maintaining negative attitudes towards HRT use. Alexander and Moore (2007) say that the media’s reporting of the WHI report caused concern regarding all forms of HRT. As a consequence, according to Kauffman et al. (2005), women (and their GPs) continue to be influenced by the WHI findings and “a willing media searching for another medical scandal “ (p.592). Furthermore, Simon and Reape (2009) suggest that “although initial findings (of the WHI study) received widespread, at times sensational, reporting in the popular media, less dramatic updates have received less attention and media coverage” (p.75).

McIntosh and Blalock (2005) and Simon and Reape (2009) also found that the media reports about the WHI study had a strong impact on women’s attitudes to HRT use. McIntosh and Blalock found that women who changed their HRT use after hearing such media reports were significantly less likely to trust the information given by their doctors about HRT. Conversely, Ness, Aronow, Newkirk, McDanel and Morley (2005), found that women in their study continued to use HRT for a number of reasons despite the negative publicity.

Women are ill-informed about the risks and benefits associated with HRT use according to Simon and Reape (2009). In their study of the menopausal experiences of professional women, they found that a number of women incorrectly identified the risks associated with HRT use. They highlighted the fact that this lack of clarity about the benefits and risks associated with HRT use existed despite these women being highly educated and successful and visiting their healthcare professionals on a regular basis.

Several studies have endeavoured to identify factors that may differentiate HRT users from non-users. For example, Twiss et al. (2007) reported that HRT users were more likely than non-users, to engage in health-promoting behaviours such as using calcium supplements, exercising and having mammograms. Bosworth et al. (2005) also investigated the factors that influence women's decisions about the use of HRT and found that the way in which women responded to the adverse findings was influenced by a number of factors. Within their study sample, women were less likely to discontinue using HRT if they had an increased understanding about HRT, were confident, had mental health symptoms, had had gynaecological surgery and held the perception that menopause is a natural process. In addition, they found that having an increased understanding about the risks associated with HRT use, mood symptoms, vasomotor symptoms, and having had gynaecological surgery were associated with a greater likelihood of initiating HRT use. The researchers said that their findings indicate the importance of physicians discussing the use of HRT with their patients, especially in light of the recent findings.

Other studies have also focused on the factors that may influence women's decisions regarding the use of HRT and other therapies. Heinemann et al. (2008) had fortuitously investigated women's opinions about the use of HRT just prior to the release (in 2002) of the WHI findings. The study was therefore considered by the authors to provide a benchmark of attitudes towards HRT use from which to measure changes since 2002. The study included over 10,000 women aged between 40 and 70 years, from nine countries across four continents. They found that for most "ever-users" of HRT in their study, the relief of hot flushes, night sweats and insomnia were rated as the most important reason for commencing therapy. Prevention of osteoporosis was rated second. In addition, they found that as well as the relief of symptoms, the absence of an increased cancer risk was also considered desirable. Factors such as possible cardiovascular benefits, improvement in well-being and protection of bone density were less highly ranked in regard to decisions about HRT use. Furthermore, women who said they were afraid of hormones in general, believed HRT use to be unnatural or that there were natural alternative preparations available were frequently from the more developed countries and held underlying negative attitudes towards HRT use.

In addition to the confusion amongst women in regard to the risks and benefits associated with HRT use, Simon and Reape (2009) report that health care professionals may also lack an understanding of the pertinent issues. They found that primary care physicians overestimated the risks associated with HRT as much as 67% of the time. Other research (Kauffman et al., 2005) also reported changes in the attitudes of doctors subsequent to the negative publicity about HRT. They found that following reports of adverse findings, many medical practices in the US were requiring patients to sign informed consent disclosure forms before being prescribed HRT. They described this practice as puzzling given that it was not applied to the prescription of many commonly prescribed extended-use drugs and the oral contraceptive pill which they said carry greater risks.

Holloway (2009) also discusses the change in attitudes among health professionals in regard to the use of HRT. She suggests that both women and health professionals may use the confusing information about the risks and benefits of HRT selectively depending on their personal beliefs. In addition, she says medical practitioners may now be reluctant to prescribe HRT because the information available to them is both confusing and contradictory. Similarly, Twiss et al. (2007) say that the ramifications following the release of the WHI findings are that many healthcare providers are no longer prescribing or recommending HRT to symptomatic women. Instead, they are waiting for symptoms to become more distressing or for the woman to raise the issue herself.

Finally, MacLennan (2009) discusses the effect of the change in attitude to the use of HRT. He says that many women inappropriately stopped using HRT after the adverse media reports in 2002 and makes the following comment in regard to this:

Ironically many women who experienced menopause after 2002 may have missed a therapeutic window for cardioprotection and possibly cognitive benefit and also suffered unnecessary menopausal symptoms if they avoided, or their advisors denied them, the option of HRT. (p. 121)

Sources of Information and Support for Perimenopausal Women

In Australia, the role of educating women and health professionals about the onset, nature and treatment of perimenopausal symptoms has been undertaken principally by the Australasian Menopause Society (AMS). The AMS may be described as the peak medical body in Australia, promoting best practice in regard to the management of issues associated with the health of mid-life women. The organisation's website (www.menopause.org.au) provides information for health professionals and the general public as well as links to other pertinent websites. According to the AMS:

The need to understand the various problems of the menopause, and their management is a major issue to doctors, politicians, health care workers, and the community; particularly when it is realised that women are not only living longer, but that their numbers are increasing at a disproportionate rate (AMS, 2010 a)

Notwithstanding that the AMS is a vital source of information it is unclear to what extent this information is accessed by women or health professionals. There is a paucity of recent research into the current sources of information for women regarding treatment of perimenopausal symptoms. According to Bosworth et al. (2005), health care providers need to be aware of the pivotal role they play in influencing the decisions of women in regard to the use of HRT and alternative treatments for perimenopausal symptoms. He says he believes this is of greater importance following the release of the WHI report in 2002 and that health care providers should take the time to discuss matters of concern regarding HRT use with their clients.

Twiss et al. (2007) recommend that health professionals allocate more time to the education and assessment of perimenopausal women and the provision of information that is accessible and consistent and empowers women to make decisions about their health and choices regarding HRT use. They cite a number of studies that indicate that women who are not well informed about HRT are less likely to use it.

Experiencing Perimenopausal Symptoms in the Workplace

There is a paucity of literature regarding the impact of perimenopause on women in the workplace. Although not recent, a study by Reynolds (1999) is quite comprehensive and her findings may still be pertinent. She claims that women's experiences at work generally, have been largely neglected by researchers and that even less is known about the impact of menopausal problems on women in the workplace. Reynolds suggests that hot flushes may become more problematic when a woman is trying to manage "particularly challenging or anxiety-provoking tasks (such as meetings or tasks requiring attention to fine details)" (p. 358). She also found that some women reported having problems with aspects of cognition such as learning or concentration during hot flush episodes.

Although Reynolds acknowledges that her study has clear limitations she raises a number of issues that she suggests warrant further investigation. In particular, she discusses the need for more research into the impact of the social stigma that she asserts is associated with being identified as menopausal. She suggests that women who may be reaching higher levels in their organisation, may at times be concerned that their poise and authority may be compromised by having their menopausal status exposed due to having hot flushes in public situations.

This sense of vulnerability continues to be an issue for women, as highlighted in a study by Morris and Symonds (2004) who interviewed women in clerical and administrative jobs within large organizations. They found that the women in their study reported that a number of symptoms such as hot flushes and unexpected heavy bleeding increased their sense of vulnerability and embarrassment.

A study by Simon and Reape (2009) appears to be one of few to date that focuses on the perimenopausal experiences of professional women. The authors say that the majority of women they surveyed reported physical and/or emotional symptoms which many believed significantly affected their personal and professional lives. In particular they found that night sweats, insomnia and hot flashes (flushes) were the most disruptive to the participant's professional lives and proved to be the most bothersome menopausal symptoms. In conclusion they say that "menopausal

symptoms can have a significant effect in the workplace. Physicians should be aware of the frequency and impact that menopausal symptoms can have on patients' lives and discuss the appropriate options available for treatment of these symptoms" (p. 76).

Finally, in addition to the impact of perimenopausal symptoms on women in the workplace, there is evidence to suggest that work and the work environment may exacerbate perimenopausal symptoms. A comprehensive report (Paul, 2003), commissioned by the Trade Union Congress in the UK, identified a number of issues of concern to women experiencing menopausal symptoms at work. In this study, 500 union safety representatives were asked to survey members about their experience of perimenopausal symptoms. Respondents reported that many of the symptoms commonly associated with perimenopause had been exacerbated by work or working conditions. These included hot flushes (53%), headaches (46%), tiredness and lack of energy (45%), sweating (39%) and menopause-related aches and pains (30%). Concerns raised ranged from practical issues such as being required to wear uniforms that did not cater for fluctuating body temperatures, to problems associated with the embarrassment and stigma that were felt by many to be associated with being menopausal.

Women Leaders in Australian Workplaces

At the core of this research is the coincidence of the age at which women may experience perimenopausal symptoms with the age at which they may be undertaking leadership roles. For example (as previously reported) the average age at actual menopause is 51.4 years and many women will enter perimenopause several years prior to this. Burgess and Tharenou (2002) say that most Australian women board directors are between 45 and 47 years of age while Kang, Cheng and Gray, (2007) found that the average board director was between 51 and 70 years of age. The most recent report by the Australian Government Corporations and Markets Advisory Committee Report on Diversity on Boards of Directors (March, 2009) showed that the average age of board directors (male and female) was 53 years. In each of these reports, the years in which women are likely to be undertaking leadership roles such

as board directorships, include the years frequently associated with the menopausal transition.

Women's participation in the Australian workforce is monitored by the Equal Opportunity for Women in the Workplace Agency (EOWA) which is an Australian Government agency consulting with Australian employers. In addition to a number of educational and other initiatives, EOWA conducts an annual census of Women in Leadership. According to the EOWA Census figures from 2008, women in leadership roles are in the minority in almost every sphere of industry. Furthermore, women become increasingly isolated as they advance to senior management levels until, at the level of Board Director, they are outnumbered by men at 10 to one and at the level of CEO, at 49 to one within the ASX200 companies (EOWA, 2009).

Furthermore, the 2008 census figures for the Australian Stock Exchange top 200 companies show a slight decrease in participation rates since the 2006 census (EOWA, 2009). In 2006, there were 8.7% of board positions held by women and 12% of executive managers were women. The report says that the number of positions for women on boards has not kept up with the increase in overall board seats. In executive management positions, they report that the numbers of women has also decreased and there is a continuing decline in the pool of women in executive management positions. In addition, the report says that the majority of women continue to be in support positions rather than in line positions which purportedly provide the experience considered essential for achieving top corporate positions. The report also says that the increase in women holding line positions seen in previous Census takings has not been sustained.

The decline (across all indicators) in women's participation in leadership roles is discussed by McPhee and Smith (2009) in the forward to the (2009) EOWA Census report. The authors highlight the decline in the proportion of women to men on corporate boards and in executive leadership roles since 2006. They say that in this regard, Australia has now fallen behind the United States, United Kingdom, South Africa and Canada. One explanation that they say may account in part for this decrease in women's participation is the growth in male-dominated industries (such as mining and engineering). They say this only highlights the gender segregation

within the Australian workforce and the problems women encounter in advancing within such industry sectors.

The failure of women to gain leadership positions within Australia's top ASX200 companies despite the implementation of a number of strategies aimed at improving the gender balance at this level was the subject of research by Nesbit and Seeger (2007). They reviewed the activities of thirty Australian organisations across three distinct industry groups (Finance and Insurance; Construction and Engineering; Health and Community Services) in regard to the actions taken to support and enhance women's participation in management roles. The following remarks were made in regard to their findings:

While overt gender discrimination was generally reported to be a matter of the past, indirect obstacles, relating to both organisational culture and wider social values, still seemed to be in existence preventing women from reaching the top levels of their organisations in equal proportions as men. Until these broader social values are challenged and dealt with the extent that organisational efforts for enhancement of women in management will continue to advance very slowly. (p. 21)

In the absence of recent Australian research, a study by Martelli and Abels (2010) explored a number of demographic variables within the population of CEOs of the Fortune 500 companies in the United States. They found that although there was an increase in the number of younger CEOs (between 40 and 44 years of age), the average age of CEOs had remained constant for a number of decades at 55.1 years of age. Female CEOs however, were less well represented within the younger age brackets being on average older than their male counterparts. The authors concluded that women needed to work harder and attain higher levels of experience and education than their male counterparts, in order to be elected to CEO positions.

Of particular relevance to this study are the ramifications for Australian women leaders working in male-dominated environments. The continued under-representation of women in leadership roles in Australia suggests that the findings of an earlier study by Gardiner and Tiggemann (1999) which indicated that being in male-dominated environments can adversely affect women's physical and mental health, may still be relevant. They describe three postulated consequences for women in these circumstances which they say have the potential to increase stress levels. These include stereotyping, exaggeration of differences and increased visibility. In particular they say, increased visibility is associated with being one of only a few women amongst a majority of men. This they say can be particularly stressful for a woman if she feels she is being constantly watched and therefore under more pressure to perform and to perform better than her male colleagues. The authors suggest that this may also result in a sense of a loss of privacy for these women.

Another issue for women leaders involves the way they may be judged in regard to the style of leadership they employ. Gardiner and Tiggemann (1999) say that when a woman leader employs a more feminine style of leadership it may "make her even more visible and exaggerate differences between herself and men even more, thereby leading to increased negative reactions" (p. 302). They cite a conclusion reached by the American Psychological Association (Amicus Curiae Brief, 1991) which may continue to have relevance in more recent times:

Sex stereotypes place women in a double bind situation. If they adopt stereotypically masculine styles of leadership that may be required for that particular job, they are considered to be abrasive or maladjusted. However, if women utilize stereotypically feminine styles, they are considered less capable and their performance may not be attributed to competence. (Gardiner & Tiggemann, 1999, p.304)

Furthermore, according to Gardiner and Tiggemann (1999) the style of leadership adopted by women working in male-dominated organisations tends to be more similar to that employed by men and conversely more interpersonally orientated when

working in female-dominated environments. In addition, women's tendency to employ an interpersonally orientated leadership style was seen to be decreased when in a male-dominated environment. This they said supported the findings of a cited study by Eagly and Johnson (1990) which found that women "adopted more typically male styles in order not to lose authority and position" (Gardiner & Tiggemann, 1999, p. 301).

Isolation is another issue for women working in mostly male-dominated workplaces according to Gardiner and Tiggemann (1999). They suggest that this isolation from other women and also from the predominantly male peer group may reduce opportunities to access both formal and informal support which may also increase stress levels. They conclude that their findings support the more general claims of a number of other researchers, that the work stressors experienced by women leaders are greater than those experienced by men. Much of this stress they say reportedly comes from being isolated, overworked and more visible than men. In addition they acknowledge that many of these stressors also apply to women leaders in female-dominated industries. An exception they say, relates to the issue of discrimination where male colleagues are seen to be treated more favourably and are perceived to have greater career opportunities.

More recently, Eagly (2007) suggests that in male-dominated environments, women find it difficult to develop helpful relationships and gain access to influential networks. The issue of exclusion from influential networks and opportunities to develop the kind of camaraderie that men take for granted at this level is also raised by Eldridge, Park, Phillips and Williams (2007). They reported that some women said they were reluctant to share personal issues or be as casual with colleagues as were their male peers. Another issue raised by Eldridge et al. (2007) concerns the paucity of strong mentorship for women in senior roles when compared to their male peers.

Eagly (2007) also proposes that women in highly masculine domains have to contend with a greater range of criticisms and expectations than their male colleagues. She says in conclusion that "given these hurdles, advancing up a highly male-dominated hierarchy requires an especially strong, skilful, and persistent woman. She has to

avoid the threats to her confidence that other people's doubts and criticisms can elicit" (p. 6).

Summary

The literature reviewed in this chapter provided the basis for the development of the research questions and directed the conduct of the study. The following chapter will address the rationale for the selection and implementation of the research methodology subsequently chosen as the most appropriate approach to explore the phenomenon of perimenopausal symptoms in the lives of the women leaders who participated in this study.

Chapter Three: Research Design

Introduction

Research regarding perimenopause and the menopausal transition has most often focussed on the physiological effects of fluctuating hormones. Consequently, studies in this area have generally used quantitative approaches in the measurement and evaluation of data. Although qualitative approaches have been used to explore various psychosocial and cultural issues associated with the menopausal transition, relatively few studies have employed qualitative approaches to explore the broader impact of perimenopausal symptoms on women's lives. Fewer still have investigated how such symptoms may affect women in the workplace and in particular, women in leadership roles. A narrow focus on the numerically measurable effects of perimenopausal symptoms is unlikely to provide the kinds of insights that may enhance our understanding of how working women in positions of responsibility experience and manage this time of their lives.

It is evident within the literature that perimenopause has often been seen primarily as a medical issue and therefore researched using approaches traditionally favoured within the medical sciences. Although research using quantitative approaches is appropriate in many instances, qualitative approaches provide a different perspective and offer opportunities to explore the ways in which people experience phenomena within their lives. In this regard, a number of health care professionals have raised their concerns about the lack of good qualitative research within the medical sciences. For example, Malterud (2001) suggests that the use of qualitative research methods could improve the quality of medical research. She makes the following comment:

Medical research needs diversity. We need to prevent methodological separatism and supremacy if the field of medical knowledge is to be expanded, not just strengthened or divided. Responsible application of qualitative research methods is a promising approach to broader understanding of clinical realities.

No research method will ever be able to describe people's lives, minds, and realities completely though, and medical doctors should be reminded that scientific knowledge is not always the most important or relevant type of information when dealing with people. (Malterud, 2001, p. 489)

More recently, Clarke (2009) discussed the value of applying qualitative approaches in health care research. She says that health professionals need to develop a deeper understanding of the experiences of clients, colleagues and carers and of the relationship between their practice and the health and wellbeing of clients.

Qualitative approaches by their very nature explore the way people make sense of their experiences. The information gathered using qualitative research can only add to our understanding and thereby enhance the way health professionals interact with their patients and clients. The rationale for choosing a qualitative research approach and in particular, interpretative phenomenological analysis (IPA) for this study will now be discussed.

Qualitative Research

Denzin and Lincoln (2005) describe qualitative research as “a field of enquiry in its own right” (p.2). They discuss at length the historical and political factors that have influenced the development and practice of qualitative research over several decades and offer what they describe as a generic definition:

Qualitative research is a situated activity that locates the observer in the world. It consists of a set of interpretative, material practices that make the world visible. These practices transform the world. They turn the world into a series of representations, including field notes, interviews, conversations, photographs, recordings, and memos to the self. At this level, qualitative research involves an interpretive, naturalistic approach to the world. This

means that qualitative researchers study things in their natural settings, attempting to make sense of, or interpret, phenomena in terms of the meaning people bring to them. (Denzin & Lincoln, 2005, p.3)

Smith (2004) says that qualitative approaches allow researchers to explore, describe and interpret participants' personal and social experiences. In particular he says that qualitative approaches enable researchers to investigate particular phenomena in a way that is not restricted by predefined categories or narrow hypotheses.

Although qualitative approaches have gained popularity within a number of health related areas such as psychology (Smith, 2004), other disciplines have been slower to embrace this methodology. For example, Ryan-Nicholls and Will (2009) say that although qualitative research methods are considered to be congruent with the goals and perspectives of nursing, there continues to be resistance to the use of qualitative approaches within many areas of medicine and public health. The authors suggest that the emphasis on evidence-based research often relegates qualitative studies to "second-class status" (p.70). They cite Morse (2006) who suggests that this may in part be due to the application of Cochrane criteria which places randomised clinical trials as the gold standard in research relegating studies using qualitative methodologies to a non-fundable status.

In addition, according to Ryan-Nicholls and Will (2009) qualitative researchers are frequently criticised for failing to demonstrate methodological rigour. They cite Maggs-Rapport (2000) who they say correctly predicted that those with a poor understanding of qualitative approaches would continue to judge qualitative studies as failing to meet the standards of rigour that are more appropriately applied to quantitative research. Furthermore, they say that although there are fundamental differences between qualitative and quantitative methods, attempts to address such concern often result in a tendency to evaluate both approaches against criteria suitable for quantitative research only. Rolfe (2006) and Smith, Flowers and Larkin (2009) also reject the notion that qualitative research should be judged according to the same criteria as those applied to quantitative research.

Ryan-Nicholls and Will (2009) outline some alternative criteria for assessing rigour in qualitative research. For example, in regard to the concept of *truth value* or internal validity, they cite Sandelowski (1986):

The search for truth is much more elusive in qualitative research. In this type of enquiry, truth value is subject-orientated rather than defined by the researcher. Truth is found in the discovery of human phenomena or experiences as they are lived and perceived by subjects as opposed to the verification of a priori conceptions of such experiences. (Ryan-Nicholls & Will, 2009, p.72)

The concept of *neutrality* which is so valued in the conduct of quantitative research is also discussed in regard to its relevance within the context of qualitative research. Ryan-Nicholls and Will (2009) say that by its very nature, “qualitative research seeks the truth by interacting with, as opposed to disengaging from, that which is being investigated” (p. 73). The disengagement that is required to achieve neutrality in the context of quantitative research is therefore diametrically opposite to the engagement and connection required in conducting qualitative research.

A key issue in all research, including qualitative approaches, is the validity of the methodology. Smith et al. (2009) cite four broad principles as suggested by Yardley (2000) which they considered to be more appropriate for assessing the quality and validity of qualitative studies than those designed for quantitative research. Each of these principles will now be outlined and their application within this study will be discussed where relevant in the following sections of this chapter.

Sensitivity to Context

According to Yardley (2000) as cited in Smith et al. (2009) demonstrating sensitivity to context is a hallmark of good qualitative research. This sensitivity may include consideration of socio-cultural issues, the published literature on the topic and the

data obtained from the study participants. The conduct of the research interview also provides an opportunity to demonstrate sensitivity to context through the interactional nature of the interview process. This can also be demonstrated during the process of data analysis in so far as “making sense of how the participant is making sense of their experience requires immersive and disciplined attention to the unfolding account of the participant and what can be gleaned from it” (p.180). Furthermore, they say that sensitivity to context can also be demonstrated through an awareness of the existing literature both substantive in regard to the topic under investigation and theoretical as it applies to the conduct of the research itself.

Commitment and Rigour

Yardley’s (2000) second broad principle, as cited in Smith et al. (2009) refers to the issues of commitment and rigour. Commitment is said to be demonstrated in a number of ways including the manner in which the researcher ensures the comfort of participants during the interview process and attends to what the participant is saying. Smith et al. (2009) say that there is an expectation that researchers have the skills necessary to undertake these kinds of interviews effectively. This commitment also needs to be demonstrated in the manner in which the data from each participant is subsequently analysed.

Rigour is concerned with the thoroughness of the study. This can be enhanced through the selection of an appropriate and reasonably homogeneous sample; use of well conducted in-depth interviews to gather the data and a thorough and systematic analysis of the data with sufficient idiographic engagement. In addition, the analysis of the data must move beyond a description of what is said, to an interpretation of the meaning implicit in the participant’s narrative. Smith et al. (2009) say that IPA studies should not only tell the reader something about individual participants but also something about the themes they have in common with others in the study.

Transparency and Coherence

According to Yardley (2000) as cited in Smith et al. (2009), transparency relates to the clarity with which the stages of the research process are written-up on completion of the study. This may include a description of how participants were selected, how the interview was conducted and the steps used during the data analysis.

The coherence of the research may ultimately be judged by the reader of the completed write-up and may relate to the coherence of any argument put forward, the apparent logic behind the clustering of themes and the way in which any ambiguities or contradictions are addressed.

Impact and Importance

Yardley's (2000) final principle as cited in Smith et al. (2009), is concerned with the extent to which the particular piece of research is considered to tell the reader anything of interest, use or importance. Yardley says this ultimately provides a measure of the real validity of the research.

In addition to Yardley's four broad principles (Yardley, 2000 as cited by Smith et al. 2009) the authors suggest the independent audit as a really powerful way to demonstrate validity in qualitative research. This requires the filing of all data in such a way that the process can be followed from the initial interviews through to the final report. They highlight the difference between this kind of audit and the type used to quantify the analysis of open-ended material. The independent audit they say is "attempting to ensure that the account produced is a credible one, not that it is the only credible one" (p. 183). In this regard, the aim is not to produce a single report claiming to represent the only truth nor necessarily to achieve some kind of consensus, but rather to acknowledge that there may be a number of possible accounts that are also legitimate. The concern they say is therefore about how transparently and systematically the particular account has been produced.

Interpretative Phenomenological Analysis (IPA)

IPA is a relatively recent approach to qualitative research. The approach originated in the area of psychology and has more recently been applied to other disciplines within the human, health and social science fields (Smith et al., 2009). Brocki and Wearden (2006) described IPA as providing a theoretical foundation and offering a “detailed procedural guide” (p. 87) for the conduct of research. Furthermore, Smith and Osborne (2004) say that IPA is an appropriate approach when investigating how individuals perceive particular situations and make sense of their personal and social world, particularly when the researcher is concerned with novelty, complexity or process. They add that within the practice of IPA, research questions are usually framed broadly and openly and there is no attempt to test a predetermined hypothesis, but rather to explore an area of concern in a flexible yet detailed way. Furthermore, within IPA the process of analysis of the raw data is iterative and ongoing and the overall aim is to provide an interesting narrative account of the emerging themes (Seamark, Blake & Seamark, 2004).

According to Smith et al. (2009) IPA has been informed by concepts and debates from three key philosophical areas including phenomenology, hermeneutics and idiography. The influence of each of these areas on the development and conduct of IPA will now be discussed.

Phenomenology

Phenomenology is at the core of IPA and is described by Smith et al. (2009) as “a philosophical approach to the study of experience” (p.11). According to Giorgi and Giorgi (2004), phenomenology “seeks the psychological meanings that constitute the phenomenon through investigating and analysing lived examples of the phenomenon within the context of the participants’ lives” (p.27).

Smith et al. (2009) describe the contributions of a number of philosophers to the phenomenological approach including Husserl, Heidegger, Sartre and Merleau-Ponty. Husserl, they say, emphasised the importance of focusing on our perceptions of

experience. This concept was developed further by Heidegger, Sartre and Merleau-Ponty who they say “each contributed to the view of the person as embedded and immersed in a world of objects and relationships, language and culture, projects and concerns” (p. 21). This *descriptive* or Husserlian approach which is distinguished by *bracketing* or *holding in abeyance*, the researcher’s theoretical impositions and pre-conception was gradually replaced by the interpretative or *hermeneutic* approach (Kleiman, 2004; Smith & Osborne, 2004; de Witt & Ploeg, 2006).

Hermeneutics

Unlike the Husserlian approach, the interpretative or hermeneutic approach considers the researcher’s conceptions to be integral to his or her ability to interpret the participant’s personal world. Smith et al. (2009) describe hermeneutics as a theory of interpretation concerned with the methods and purposes of interpretation itself. By its very nature, the interpretative approach provides both the researcher and the participants with an opportunity to play a role in a “dynamic research process” (Clarke 2009, p.37).

Idiography

Idiography also exerts a major influence on IPA according to Smith et al. (2009). They describe idiography as being concerned with *the particular* in contrast to being *nomothetic* or concerned with establishing general laws about human behaviour and making claims about groups or populations. The authors assert that this idiographic commitment is demonstrated in IPA firstly through IPA’s commitment to being particular about the detail and therefore the depth of analysis, and secondly in its commitment to understanding particular experiential phenomena from the perspective of particular people within a particular context. They say that as a consequence of this “IPA utilizes small, purposively-selected and carefully-situated samples, and may often make very effective use of single case analyses” (p.29).

In regard to the conduct of IPA, Smith and Osborn (2004) say that there is no definitive way to conduct IPA but rather researchers may adapt their approach according to the topic under investigation. They summarise the core philosophical basis of IPA as follows: “IPA has a theoretical commitment to the person as a cognitive, linguistic, affective and physical being and assumes a chain of connection between people’s talk and their thinking and emotional state” (p.52). Furthermore, Smith et al. (2009) say that “IPA is concerned with the detailed examination of human lived experience. And it aims to conduct this examination in a way that as far as possible enables that experience to be expressed in its own terms, rather than according to predefined category systems” (p.32).

Finally, it is considered pertinent within the context of this study, that the approach used in IPA is congruent with many of the principles of feminist methodology, as outlined by Neuman (2003) and Seibold (2000). Seibold describes what she considers constitutes a feminist research:

A typical checklist of what characterises feminist research is as follows: the principal investigator is a woman; the purpose is to study women and the focus of the research is women’s experiences; the research must have the potential to help the subjects as well as the researcher; it is characterised by interaction between researcher and subject and by non-hierarchical relations, expressions of feelings and concerns for values. (Seibold, 2000, p.151)

The Rationale for Choosing IPA for This Study

This study sought to explore the phenomenon of perimenopausal symptoms as experienced by women in leadership roles. The intention was to explore this phenomenon in a way that would enable the participants to provide deeper, personal insights which may not be generated by research using traditional quantitative approaches. To achieve such insights it was considered important that data be gathered in a manner which would be least likely to pre-empt or in any way limit the scope of the participants’ responses. Therefore, a qualitative methodology was chosen

as the most efficacious method for this study. Furthermore, IPA as an interpretive phenomenological approach was considered the most appropriate because it provided a framework that enabled the exploration and interpretation of the meaning ascribed by women in leadership roles in regard to their experience of perimenopausal symptoms.

Method

Participants and recruitment.

Purposive sampling was used to recruit 17 participants, including parliamentarians, executives from corporate, government, non-government, not-for-profit organisations and academic institutions. The method of recruitment ensured a degree of homogeneity among study participants in regard to their experience of the phenomenon being explored (Seamark et al., 2004; Smith & Osborn 2004; Guest, Bunce & Johnson, 2006; Smith et al., 2009). The approach is also consistent with IPA practice and the aforementioned commitment to ensuring rigour within the study. Furthermore, Neuman (2003) says that purposive sampling is appropriate when the researcher wants to recruit individuals from a “difficult-to-reach, specialized population” (p.213). Due to both the nature of the research topic and the leadership status of the prospective participants, the population targeted within this study could well be described in this way.

According to Smith and Osborn (2004) decisions about sample size in studies using IPA are based on a number of factors. These included consideration of the time constraints; level of commitment of the researcher and the richness of the data obtained from the interviews. Although Smith and Osborn maintain that there is no right sample size, they suggest that the analysis of larger data sets may result in the loss of “potentially subtle inflections of meaning” (p. 54). According to the broader literature on IPA studies, as reviewed by Brocki and Wearden (2005), participant numbers in IPA studies varied from one to 30. Smith et al. (2009) suggest that historically, qualitative researchers opted for larger sample sizes in order to avoid criticism from their quantitative colleagues. They say that as more studies are

published and the approach gains a level of maturity, sample sizes are falling. They recommend that between four and 10 interviews may be sufficient for a study at professional doctorate level.

Due to the sensitive nature of the study topic, it was considered important to recruit participants in a manner which protected them from being identified as perimenopausal. It was therefore decided that publicly advertising the study either within the community or workplace would be inappropriate. Rather, a less direct recruitment process was used whereby individuals within the realms of the researcher's professional networks were asked to approach colleagues or friends who were deemed to be in leadership roles (as defined for this study) and who they thought might be interested in taking part in the study. Potential participants were then invited to contact the researcher if they were interested in receiving further information about the study. This initial approach also resulted in a *snowballing* effect whereby prospective participants subsequently informed others within their networks about the study.

It is important to note that a great deal of consideration was given to the process of recruitment in regard to the risk of causing offence by approaching someone who may not have considered herself to be perimenopausal. Those asked to approach others all professed to being mindful of this and agreed to undertake the task with great sensitivity. To the knowledge of the researcher no one was offended by being asked to participate and this was a tribute to those involved in helping in the recruitment process and also to the women who subsequently volunteered to participate.

The women who subsequently expressed an interest in participating in the study were provided written material including: information about the study as required by the UNDA Ethics Committee (Appendix B); information regarding the terms used in the study (Appendix C); a Symptoms Checklist (Appendix D). The symptoms checklist was a composite of checklists used by the Keogh Medical Centre (adapted with permission, Dr Natalia Kowal, November 16, 2007) and the Australasian Menopause Society (AMS, 2008 a). The decision to provide this information to potential participants was based on research by Lyndaker and Hulton (2004) as outlined in the

previous chapter, which found that women often fail to recognise certain perimenopausal symptoms. It was intended therefore, that the provision of this information would enable potential participants to more accurately determine their eligibility for inclusion in the study. The checklist was also used as a catalyst for discussion of symptoms during the interview.

The 17 leaders who subsequently agreed to take part in the study all signed the Consent Form (Appendix A) as required by the UNDA Ethics Committee, completed the interview process and provided information for the study.

Data collection.

Qualitative data were gathered through audio-taped, in-depth, semi-structured interviews.

Smith et al. (2009) describe the qualitative research interview as “a conversation with a purpose” (p. 57). Smith and Osborne (2004) say that the semi-structured interview method is considered the exemplary method for IPA. They assert that this form of interview allows greater flexibility and enables the interviewer to go into novel areas and thus produce richer data. In addition, they say this approach acknowledges the participant as the perceived expert in the telling of their story. According to Reid, Flowers and Larkin (2005), one-to-one interviews enable interviewer and respondent to “work in flexible collaboration, to identify and interpret the relevant meanings that are used to make sense of the topic” (p. 22).

Rubin and Rubin (2005) use the term *responsive interviewing* rather than in-depth interviewing to highlight the interactive nature of the interview process which they also say should generate a depth rather than a breadth of understanding. They emphasise the importance of recognising the mutuality of the relationship between the interviewer and interviewee as *conversational partners*. The main goal of responsive interviewing, they say, is to achieve a deep understanding of what is being studied and they describe the process of achieving this as follows:

Research design and questioning must remain flexible to accommodate new information, to adapt to actual experiences that people have had, and to adjust to unexpected situations. The researcher creates future questions based on what he or she has already heard, requiring the researcher to analyse interviews throughout the project rather than just at the end. (Rubin & Rubin, 2005, p 35)

As discussed earlier, in-depth interviews also enable the researcher to engage with the participant in a manner that contributes to the rigour of the research process. Smith et al. (2009) describe a good in-depth interview as essential to IPA. Furthermore, they say that “unless one has engaged deeply with the participant and their concerns, unless one has listened attentively and probed in order to learn more about their lifeworld, then the data will be too thin for analysis” (p. 58).

As an experienced mental health counsellor, this researcher applied the skills of active listening, paraphrasing and prompting to ensure that each participant had the opportunity to relate her story openly and in a manner that contributed to the exploration of the research topic. The interviewer was mindful however, of the need to avoid taking on the role of counsellor within the interview process. When appropriate, at the conclusion of the interview the researcher discussed particular issues of concern that had been raised in the interview and provided information about further sources of advice and support.

Smith et al. (2009) recommend that an interview schedule be prepared in order to set a loose agenda for the interview process and to enable the researcher to think more deeply and explicitly about the content and scope of the interview. Furthermore, Smith and Osborn (2004) say that consistent with the concerns associated with an approach such as IPA, the interview schedule should provide a guide to the interviewer rather than dictate the course of the interview. They say that this enables the interviewer to feel free to probe interesting issues raised by the participant and follow areas that are of interest or concern to the participant.

All interviews were undertaken by the researcher in an environment that ensured each participant's comfort and privacy. According to Kleiman (2004), undertaking the dual role of collection and analysis of data enables the researcher to achieve the richest appreciation of the rendered descriptions. In addition, it was considered that having only one interviewer would ensure optimum consistency in data collection. The place and time of the interview were decided by the participant.

Smith et al. (2009) highlight the importance of establishing rapport with participants if meaningful data is to be obtained. Given the sensitivity of the research subject, establishing rapport through perceived (and genuine) empathy was considered essential to the research process. The researcher's gender, age, and both personal and professional experience of perimenopause was considered vital to the development of the level of rapport considered necessary to gain participant's confidence and elicit open dialogue. Rubin and Rubin (2005), cite Aston (2001, p. 147) who asserts that personal disclosure is essential in that it increases the comfort levels of the participant and facilitates a degree of "trust and mutuality".

Following initial introductions to facilitate mutual rapport, the symptoms checklist was used as a catalyst for discussion. Participants were only prompted to discuss a particular symptom they had checked if they did not spontaneously do so. If there was any reluctance to discuss a checked symptom the issue was not pursued. Prompts were only used if it was considered that the participant's narrative had not addressed the research questions. In most cases, discussion of specific symptoms led to revelations about the broader issues associated with the experience of perimenopause, coping strategies, attitudes to treatment options and the implications of this in regard to the participant's role as a leader. Finally, if not spontaneously mentioned, participants were prompted in regard to providing their recommendations for other women in similar circumstances (Research Question Four).

Within this study, data analysis began with the transcription of each interview. Following initial analysis of the 17 interview, it was decided that little would be added to the research findings by conducting further interviews. Charmaz (2004) describes the point at which it is considered that no new insights would be gained by gathering further data as *category saturation*.

Data analysis.

According to Smith et al. (2009) there is no single approach to data analysis in IPA, but rather a degree of flexibility and a clear focus on exploring participant's attempts to make sense of their experiences. They describe data analysis in IPA as follows:

IPA can be characterized by a set of common processes (e.g. moving from the particular to the shared, and from the descriptive to the interpretative) and principles (e.g. a commitment to an understanding of the participant's point of view and a psychological focus on personal meaning-making in particular contexts) which are applied flexibly, according to the analytic task. (p.79)

Consistent with IPA practice, the process of data analysis in this study began with the interpretation of individual transcripts. This process was begun following each interview as recommended by Rubin and Rubin (2005). According to Smith and Osborn (2004) the central issue is to explore the meaning ascribed to the participant's experiences and to try to understand the content and complexity of these meanings rather than to measure the frequency with which they occur.

The qualitative data management package NVivo 8 was used to assist with the development of a number of superordinate themes as outlined by Smith and Osborn (2004) and Larkin and Griffiths (2004). In this regard, where the authors recommend the use of left and right hand margins on individual transcripts to record emerging themes, NVivo8 provided the option of transferring identified themes directly into *free nodes* and subsequently *tree nodes* which are coded to enable linkage back to the passage within the transcribed narrative. This provides a high level of transparency within the study, enabling the accuracy and context of the data to be easily checked and thereby further contributing to the rigour of the study as outlined by Smith et al. (2009).

According to Smith and Osborn (2004) a number of factors influence the selection of themes rather than simply their prevalence within the data. These factors include the

richness of particular narrative that may highlight a particular theme and the way in which a particular theme may relate to other aspects of an account. Utilizing NVivo 8 to manage the data, the process was therefore conducted as follows:

- Individual transcripts were read and re-read in order to identify any comments made by participants that were considered to be related to the research questions. All the resulting data (excerpts from the participants' narrative) were included as findings of the study. This process was iterative and produced a number of themes that included the terms used by the participants to represent their experiences and concerns.
- This process was continued with each transcript.
- After the process of identifying themes was completed, emerging clusters of themes were identified. This process involved the categorising and re-categorising of themes in an explicitly interpretative process that reflected both commonalities and differences in the data from individual transcripts.
- Connections between themes were identified and reassessed in relationship to the original transcripts. The emerging clusters of themes were subsequently labelled and represent the four emergent superordinate themes.
- Emergent superordinate themes were then analysed with the findings subsequently presented in Chapter Four.
- Finally, a discussion of the findings with linkage to the extant literature is presented in Chapter Five.

Transferability of the Study Findings

As discussed earlier, qualitative research has often been judged according to criteria more appropriate for judging quantitative approaches. For example, Malterud (2001,

p. 486) discusses the concept of *transferability* saying that the findings from analysis of qualitative data may only constitute “descriptions, notions, or theories” (p. 486) which are applicable within a specific setting and not to the population at large. As with most research using qualitative approaches, the intention of this study was to explore the lived experiences of the women in the study group in order to develop a greater understanding of the phenomenon under investigation. The findings from the study are not intended to be transferable to other populations but may however be used to inform the direction and nature of further research including that which employs quantitative approaches.

Ethical Considerations

There were a number of ethical considerations that were required to be addressed prior to and during the undertaking of this research. These considerations will now be outlined.

Informed consent.

It is a requirement of the University of Notre Dame Australia Human Research Ethics Committee (HREC) that those engaging in research involving human subjects obtain informed and voluntary consent from respondents prior to their participation in the study. In accordance with these requirements, signed Consent Forms (Appendix A) were collected from each respondent and respondents were provided with pertinent information about the study (Appendix B; Appendix C).

As participants in this study were English-speaking adults in leadership roles, all were able to provide informed and voluntary consent as required by the HREC. However, as the research methodology involved one-on-one interviews on a subject (perimenopause) about which participants may have been sensitive, participants were advised of their right to withdraw consent during the interview and to review, edit or erase the recording or transcript of the recording of the interview prior to its inclusion in the study.

Confidentiality and anonymity.

According to McHaffie (2000), as cited in Walker (2007), research involving face-to-face interviewing makes participant anonymity impossible. Confidentiality will be protected, however, in a number of ways as described earlier and as required by the HREC. Neuman (2003), cites Singer et al. (1995) who found a “modest” improvement in responses to highly sensitive topics when researchers assured participants about confidentiality. To ensure that participants achieved this level of assurance, the issue of confidentiality was discussed prior to the commencement of the interview.

Honesty and trust.

It was anticipated that approval of this project by the HREC would provide participants with some reassurance regarding the legitimacy of the research and the obligations of the researcher to behave in an honest and trustworthy manner. Beyond this, if the researcher’s approach had failed to elicit the trust of the participant it was considered unlikely to promote the rapport required for the transaction of information considered to be of value to the research. To develop and maintain the level of trust that was required in order to elicit meaningful data, it was considered essential to promote a sense of transparency about the research process. In this regard, the concept of consent as “an ongoing transactional process” (Walker 2007, p. 41), was pertinent because if a participant had lost trust in the researcher at any stage in the process, she may have chosen to withdraw her consent and her data would have been lost to the study. This did not occur and all participants indicated that they had been comfortable with the interview process with many adding that they had found the experience both informative and enjoyable.

Reciprocity.

Once a participant had (as required by the HREC) been duly informed about the nature of the research and the obligations of the various parties involved, it was

anticipated that her decision to take part indicated that she considered the project had some merit. Beyond the expectation that her involvement may in some way be able to contribute to the greater good, it was conceivable (and certainly the desire of this researcher) that through her participation in the study, a participant may gain a greater awareness of the issues surrounding perimenopause. It was also anticipated that as well as gaining some personal benefit, participants may subsequently be better able to support female colleagues and women under their management and perhaps influence occupational health and safety policy around this issue within their workplace.

Intervention and advocacy.

It was considered appropriate to explain to the participant that there was implicit in the interaction some *duty of care* that required the researcher to terminate the interview and refer the participant to the appropriate service (counsellor or occupational health service provider) if information revealed during the interview had raised concerns about the wellbeing of the participant or another party. The researcher did not undertake the role of counsellor or advocate and was prepared to encourage any participant making such a request to seek the appropriate service to meet their needs. The need for this action did not arise during any of the interviews.

Beneficence and non-maleficence.

Walker (2007) says that beneficence and non-maleficence are among the most fundamental ethical principles applicable to research. The use of semi-structured interviews and IPA was considered the most efficacious methodology for this study as it enabled the researcher to develop the rapport considered necessary in order to elicit candid responses from the participants. It was acknowledged however, that given the nature of the research topic, this approach may have (under the HREC guidelines for assessing level of risk), constituted *highly personal interviewing* using an *intrusive technique*. As discussed above, the subject matter of this research may have been considered highly sensitive by many of the study participants and it was

therefore essential that participants were encouraged to feel comfortable with the researcher and confident about confidentiality.

Siebold (2000) discusses the problems associated with the revelation of highly personal information by participants during an interview in which an empathetic relationship is established. This relationship, although likely to be conducive to the gathering of information pertinent to the research, can also become problematic if the interviewer is recruited into the role of counsellor. Care was taken to ensure that the interviewer maintained the role of researcher and was prepared to terminate the interview if it was felt the needs of the participant were not being met, or were being compromised in any way by the interview process.

Mitchell and Lovat (1991) discuss the concept of non-maleficence in the context of its association with the maxim “above all, do no harm”. In regard to this research, the intention of the researcher was to ensure that the interview process was of some benefit to the participants, and to be vigilant in ensuring that no harm was done to participants as a result of the interaction. As discussed above, an interview would have been discontinued if it had been considered that the process was having a negative impact on the participant. To ensure the participants were able to enhance their understanding of the issues under discussion, at the completion of the interview, participants were directed to the website of the AMS (www.menopause.com.au) for information about perimenopause, support services and a list of AMS trained general practitioners in their vicinity.

The issue of power.

O’Leary (2005) discusses the need for researchers to “recognise the political nature of research and to manage the position of power afforded the researcher (p.43).” It was expected that the issue of power would be less problematic in this study because the participants were in leadership roles and thus less likely to be at risk of feeling intimidated by either the researcher or the interview process. It was evident during each of the interviews that the participants, by virtue of their job roles, were in positions of power and authority themselves and therefore unlikely to feel intimidated

by the researcher. In addition, the fact that the researcher was also a woman and of similar age who revealed having had personal experience of perimenopausal symptoms appeared to further preclude any possibility of participants feeling that they were in any way at a disadvantage.

Reflexivity.

According to Walker (2007), the most critical ethical obligation of a researcher conducting qualitative research, is to interpret the experiences of others in the most faithful way possible. Reflexivity refers to the concept of acknowledging that the actions and decisions of the researcher will affect both the meaning and context of the participant's experience. In this regard, research is seen as a joint enterprise between researcher and participant (Ashworth, 2004; McBrien, 2008). Although there is some debate in the literature about the extent to which a researcher should reflect on his or her biases and prejudices and how these may affect the rigour of the study (McBrien, 2008), the interpretive approach considers the researcher's conceptions to be integral to his or her ability to effectively interpret the participant's personal world (de Witt & Ploeg, 2006; Smith & Osborne, 2004). Within this study, the interview method selected, the conduct of the interview and the process used in the analysis of the data ensured that the best effort was made to provide an authentic representation of the lived experiences of the participants.

Summary

This researcher used qualitative research methodology faithfully to explore the phenomenon of perimenopause and its effects on women in leadership roles. Every aspect of the study including the recruitment process, interview method, data collection and analysis were designed to ensure that the experiences of the participants would be explored in a meaningful and respectful manner with consideration of the sensitivity of the study topic. The generosity of the participants in talking frankly about a very personal matter was greatly appreciated. Their stories and

valuable insights, which represent the study findings will be presented in the following chapter.

Chapter Four: Presentation of Findings

Introduction

The aim of this chapter is to present the findings of the study in a manner consistent with the methodological approach outlined in Chapter Three. The presentation of the findings as superordinate themes represents the final stage of the process of data analysis which began during the interviews. This process continued as each transcribed interview was subsequently read and re-read until a number of pertinent themes emerged. These themes and the emergent superordinate themes constitute the findings of the study.

As discussed by Smith et al. (2009), superordinate themes represent a construct that evolves through a process of exploring connections, patterns and differences in the data. From the time of interview until the final distillation of emergent themes into superordinate themes, the process is iterative and there may be a number of equally valid ways to represent the participants' experiences. Providing extracts of the participant's narrative as it contributed to each of the themes enables the reader to follow the process of analysis as it evolved for the researcher and subsequently informed the development of the constructs that represent the four superordinate themes. According to Smith et al. (2009), this process also contributes to the rigour and transparency of the study as outlined in the previous chapter.

Conventions Used in the Reporting of Findings

A number of conventions are used throughout the chapter to ensure consistent and clear presentation of the data. These conventions are as follows:

- Direct quotes from participants are indented and in italic typeface. No attempt has been made to correct grammatical errors.

- Italic typeface is also used to denote the use of words or phrases from the participants' narrative when these are cited within the researchers accompanying comments.
- The beginning and end of individual quotations are identified by a forward slash /.../. Separate quotes from different parts of the same interview may be grouped in one paragraph if considered appropriate.
- The use of square brackets [] within direct quotes indicates the researcher's additions. Additions are only used when they are considered necessary to reduce confusion and ensure clarity of meaning and context for the reader.
- The insertion of (...) within direct quotations is used to protect the identity of participants or organisations.
- The insertion of indicates that the intervening text (such as small talk) is considered irrelevant to the context and meaning of the quote.

To ensure the anonymity of participants, coding of quotations which enables direct reference to its location within a specific transcript has been removed from this document as it is considered that linkage of several quotes from one individual may enable identification of that individual. The master document, which is retained in a secure location by the researcher, includes these codes and may be made available if required for verification of authenticity or clarification of the context of quotations.

Presentation of Findings

The presentation of findings commences with a brief report of participant's comments regarding the symptoms checklist, followed by the findings associated with the four emergent superordinate themes. Responses to Research Question Four (What are the recommendations for educating and supporting women in similar circumstances?) are then reported. The chapter concludes with the presentation of other pertinent issues

raised by the participants that did not relate directly to the research questions but were considered pertinent to the research topic.

Participants' comments regarding the symptoms checklist.

As discussed earlier, a number of symptoms may be associated with the hormonal fluctuations that characterise perimenopause. Although many of these symptoms may be experienced at any time of life, there is often a change in the frequency or intensity of the experience of a particular symptom that indicates that a woman may be perimenopausal. Symptoms checklists such as the list used in this study are often used by health professionals to assist in assessing whether a woman is *likely* to be perimenopausal.

For the purpose of this study, the symptoms checklist was not intended to be a definitive list of possible perimenopausal symptoms but rather as a guide to participants in assessing their perimenopausal status and subsequent suitability for the study. The list was also intended as a catalyst for discussion about the experience of those symptoms. A number of participants raised their concerns about aspects of the checklist and the nature of some of the symptoms listed. Their comments follow:

One leader indicated that her response to the checklist may be variable over time.

/ I think that's what's interesting is that that's a big list and..... at times I could tick all of those. /

A number of participants questioned the legitimacy of attributing particular symptoms to perimenopause when they believed that life circumstances at the time could have been responsible for changes they were experiencing.

/ When I looked at these symptoms I thought, which part of the symptoms is associated with menopause and which part is associated with starting a new and very challenging job at the time? /

/ I don't think it was particularly different. I usually wake up and worry about the world, anyway..... I do remember not sleeping well, but that could have been work or it could have been anything. /

/.....I think all those things certainly occur, but I don't know that I would directly apportion them just strictly to menopause. That's why I sort of really didn't tick them because most of them are probably more of once again an ageing process or a time in your relationship when it sort of changes. /

A number of participants reported finding the checklist useful as a prompt or reminder about symptoms that they may have experienced in the past.

/..... I would have, perhaps thought of that but not necessarily...../

/..... it's a useful list because.... it makes you think..... particularly when it's not currently happening..... /

For some the list was reportedly helpful as a way of identifying symptoms they may not otherwise have associated with perimenopausal changes.

/when I was ticking these boxes..... I thought 'I never would have put that down', but that was actually a lot about how I was feeling...../

/definitely that sort of crawling under the skin; until I saw that symptom there I would never have linked it. /

/..... probably if you'd asked me to list, or what are the things..... I would have said the temperature, the hot flushes, the other bits and pieces, but not anything else...../

/..... actually it's only now reading that...../..... that makes me think, putting that together, actually in terms of looking at the list. /

One leader said she had not been aware of the difference between perimenopause and menopause until she read the definitions provided before the interview.

/I didn't actually realise what the definition of menopause was until I read your information sheet, but I hadn't come across the perimenopause period as being the period when you probably experience a lot of the symptoms before menopause rather than menopause being when all the symptoms sort of start springing up. /

A number of leaders made general comments about when they first noticed changes that they believed heralded the onset of perimenopause. These comments follow:

After being asked when she had first experienced perimenopausal symptoms, one leader responded

/..... probably over the last 12 to 18 months, like a lot of these things they sneak up on you, reasonably unexpectedly in some sense in that I think, for me, fairly gradual so there wasn't any big event where I could go 'God! that's when it all..... my body really started to fall apart'.....it's more, I've noticed it and then you put two and two together and go like 'Oh God! I guess this is what it's all about'. /

Another leader expressed some doubts about whether the changes she experienced during her 40s were associated with perimenopause.

/ For me, those things I think all possibly started around my 40's, early 40's, and I don't know whether that is perimenopausal or not, but I think that in my early 40's was when my life changed, so I sort of put it more down to, well, I have thought about it more in line with that ./

One leader reportedly experienced perimenopause *a little later* than most women and her symptoms were sporadic.

/I probably started about three years ago, so I would say..... I was probably a little later than most people, about 53. I would get a spate of sort of hot flushes over a period of a number of weeks and then they would stop and I wouldn't get anything for about two or three months, and then it would sort of start again. And then progressively, I think as I have got older-they seem to be more frequent. However, I have noticed recently that I'm probably not getting as many. /

Erratic periods heralded the onset of perimenopause for another leader.

/I think I was probably in my late 40s when I first experienced the symptoms, the menopause symptoms, the pre-menopausal stuff, and it was with very erratic periods. /

The next section will focus on the four emergent superordinate themes and their constituent clusters of themes.

The following table is included to provide an outline of the relationship between the emergent themes and superordinate themes.

Table 1

Emergent Superordinate Themes and Their Constituent Themes

Superordinate Theme One: Distraction, disruption, discomfort and distress

Disturbed and interrupted sleep
Hot, sweaty and red in the face
I mourn the loss of my libido
Don't wear white!
Irritable, anxious, feeling low
A bit more forgetful, less on the ball
Erratic, loony, emotionally driven extreme behaviour

Superordinate Theme Two: Soldiering on or taking control

Just get on with it!
Time out
Seeking support
I like my doctor
I just don't like taking tablets
I'm dead or I'm on HRT

Superordinate Theme Three: Keeping up appearances

Fronting up and putting on a bit of a face
Show your weakness and you are lost!

Superordinate Theme Four: It's lonely at the top

No one to talk to
A no-go-zone

Superordinate Theme One: Distraction, Disruption, Discomfort and Distress

All participants reported experiencing some degree of distraction, disruption, discomfort or distress associated with perimenopausal symptoms. Participants did not always choose to talk about symptoms they had checked on the list. Gentle prompting was used to initiate discussion if a checked symptom was not raised by the participant. If the participant indicated a reluctance to enter into further discussion, the issue was not pursued. In addition, some participants discussed symptoms that were not on the checklist but which they believed were related to the hormonal changes associated with perimenopause.

Disturbed and interrupted sleep.

Leaders described changes in sleep patterns that they believed were associated with perimenopause. Many of those experiencing *sleeplessness* also reported experiencing *night sweats*. Only one leader checked night sweats without also checking sleeplessness. Despite the frequency with which both symptoms were reported together, disrupted sleep was not always attributed to night sweats. A number of leaders were unable to identify the cause of their disrupted sleep.

/..... some times I'll fall asleep for a couple of hours and then I'm awake. But there's also times when I just don't feel sleepy and I may go to bed feeling tired but I just can't sleep and then you fall asleep at four o'clock and the alarm goes off. /

/.....the night sweats where they have come maybe three nights in a row, and I have had to get up and disturb my sleep and all that sort of stuff..... /

/.....I wasn't waking up in a wet bed. A lot of women lie in this pool of sweat; no, that wouldn't have happened, but I would wake up a lot of times in the night. /

/ I will sleep and I will go off, but if I don't, I sort of can be an hour, an hour

and a half, before I can go to sleep, and then waking during the night and not being able to go to sleep. /

Some leaders specifically commented on how their sleep quality had changed.

/ I've had interrupted sleep now every night for three years or four years, whereas before I would go to bed and I would sleep and I would wake up. /

/ sleeplessness only in the last 2 months //..... and I'm an extremely good sleeper, never actually wake up and noticed that. And it's not every day but on occasion I'll wake up and it'll be 3 o'clock in the morning and I'm awake and that's it but then I'll go back to sleep. But it's quite unusual for me to have that; it's just been in the last couple of months. /

/ I don't sleep as well now as I used to, and I think probably certainly since the menopause symptoms started I will wake on the average probably two or three times a night for no particular reasons. I guess I put it down to being a menopausal symptom. Generally I'm quite a light sleeper anyway, but I will just wake. / As a general rule I do [go back to sleep], unless I've got a lot on my mind for work because that is when the activity in the mind starts.// But, yeah, I'm nowhere near as good a sleeper as I once was and I find that after, say, six, six and a half hours I find it a struggle to sleep beyond that amount of time. /

/ I was waking up at 3.00 in the morning, getting up and doing some work, even sometimes going into the office and then coming back home for breakfast, // I was under enormous pressure, and I think it was all happening around about that time..... that's when the sleeplessness would have started, but then it would have gone on for the next couple of years. /

Finding the term *crawling feelings under the skin* on the checklist provided one participant with a description of a sensation she had experienced and which she found had disturbed her sleep.

/..... definitely that sort of crawling under the skin; until I saw that symptom there I would never have linked it. /I tend to wake up with a feeling that is not quite itchiness because it is not that you can scratch it and make it go away, but there is a definite irritability that then makes me quite cross, I have to say because you find trouble going back to sleep and you have to just say, 'Ignore it, ignore it.' It is a bit like a mosquito bite or something. /

A number of participants talked about the association between their disrupted sleep and night sweats.

/I would say probably more in the last six months I've woken up a number of times at night covered in sweat and no reason for that, which is most unpleasant. I remember women describing how awful it is and they are absolutely right. I mean, your hair is wet, the pillow is wet and it is just awful. /

/.....the major thing for me would be the, the night sweats and the hot flushes, and I'd say the hot flushes aren't bad in terms of what I've read about or heard others talk about, but the night sweats are full-on and I guess just generally sleeping less well than I used to...../

/I would say that in the, the last, probably six months or so, six to nine months, some of that sleeplessness is associated with, like, like actually waking up because I'm really sweating and just being uncomfortable, particularly in winter; throw the doona off and then half an hour later you're scrabbling around trying to find the doona again. So that sort of interrupted sleep and a bit of just hearing the clock chime every hour. /

/I have had a number of them [night sweats] where they have literally woken me up and I'm just absolutely drenched and feeling very uncomfortable. I just sometimes sort of get out of bed and virtually change just to get back to sleep, because sometimes I've woken and think, 'Oh, I feel really wet' and I would just like to roll over and go back to sleep again and I just can't. /

One leader made a distinction between sleeplessness and having an interrupted night's sleep because of hot flushes.

/ I wasn't sleepless, but it is just that your bloody hot flushes wake you up in the night. You know, it wasn't that I wasn't sleeping; it is just that you have an interrupted night's sleep and you get fed up with it. /

Another leader found a number of things disrupted her sleep.

/ You might get up because you had to go to the toilet or because you are hot, and often it is both. /

One leader talked about having a recurrence of her sleeplessness more recently after coming off HRT.

/.....the only thing that is still with me is I don't sleep. Sleeplessness is a real issue.//If I go to bed at 10, I'll wake up at 11.00 and wide awake and then I only seem to doze from then on. I mean, occasionally I take a Temazepam or something, half of one, just to try and knock myself out, but even that doesn't work./

Interrupted sleep reportedly caused a number of participants to be *anxious* or concerned.

/ I mean I'd wake up and I still do this sometimes, and I can't go back to sleep//..... and you know you're just awake for hours and hours and hours.//.....you can get into a cycle of just being anxious about not being able to sleep.//.....yeah well I mean the busier I am the more I know it happens...//..... more things are on my mind and you know I think that's true whether you're menopausal or not menopausal.....//..... that was probably the worst, sleeplessness, and I still have some sleeplessness now...../

/ I just get to the point where I am just so exhausted that I just lie in bed and go, 'Just bloody well go back to sleep!' /

/ I guess most of the time my main concern is I'm waking up three or four times in the night. /

In contrast, one leader believed that it was her anxiety that was the cause of her disrupted sleep.

/.....it was anxiety that would wake me at night, and I keep reading about stress and what have you, and work was stressful. Work seems to have always been stressful and yeah, waking up with work churning through the brain and all of that sort of stuff..... /

A number of participants talked about the impact of their disturbed sleep on their ability to function optimally during the day.

/..... it caught up with me on me on occasions, and there were several occasions when around lunchtime I just had to shut my door and just put my head down, like a nanny nap, and I would be fine. /

/..... if he had called a meeting at 1.00 o'clock, I knew that I would be dozing off..... this didn't happen every day, but there were days when I just thought, 'I've just got to put my head down for five minutes' and then I was fine. /

/.....certainly I think the nights when that has happened [sleeplessness], I do wake up and the next day feel quite tired, and I'm sure that has had an effect on my working day. /

Participants talked about being unusually tired or exhausted. One attributed this directly to hormonal changes and resorted to using HRT to manage the symptom while another attributed her tiredness to interrupted sleep.

/..... the thing that really did impact me at work was unusual tiredness. I did go through a period of hardly being able to get out of bed, like not even being able to put your foot out of the bed in the mornings because you're just so tired and might have even slept well at night and that's what pushed me into HRT for a

little while. The unusual tiredness was debilitating, was most debilitating.//..... it's not just a lack of sleep tiredness, it's right in the core of your bones. You're just like ' I can't get up, I can't do this' - and I'm a very high energy person so not being able to get up.....// I was not able to function really, I was so tired and that made it difficult at work. /

/..... just tired exhausted.....//.....I try to manage that by not getting too tired and exhausted so if I've had a couple of nights of, of really bad sleep, trying to go to bed early and of course you know that doesn't really guarantee anything. /

Another leader who had previously experienced *chronic fatigue* talked about her concern that symptoms she was experiencing may have heralded a relapse of this condition.

/ I had chronic fatigue.....and I had that same sort of malaise coming over me again. I thought I had better go back and just check. she [the GP] did blood tests and hormonal level checks and all that sort of stuff and it all came back perfectly. /

Hot, sweaty and red in the face.

The majority of participants reported experiencing hot flushes. Although a number of those subsequently began using HRT they were able to talk about hot flushes experienced in the time prior to or after ceasing the use of HRT.

In addition to the distraction associated with having a hot flush and her concerns about whether her face was red, one leader talked about feeling *sweaty* and *dirty* as a result of the changes in her body temperature.

/ I'm going clammy inside my clothes and trying to sit in a meeting and look like I know what I'm talking about and all I'm thinking about is. 'my God! is my face red?' and I'm feeling dirty 'cause you feel sweaty and that isn't very pleasant.....//..... didn't feel fresh. It's like when you've been for exercise and

you're sweaty and the first thing you want to do is get in the shower and I kept feeling like I needed a shower and I..... they weren't even bad, really, really bad for me. But to be sitting 'round the table discussing something highly important and you have to start speaking and your face went red would be..... it's bad enough just feeling it coming on it's like 'Oh far out'. /

The experience of having a hot flush while in a meeting was reportedly both uncomfortable and a *distraction* for one leader.

/I can feel them when it is happening. I just feel this sensation coming, overwhelming, over the body, and I think, 'Oh my God! Here I go breaking out.' I can feel the redness coming through the face, but generally in most cases it probably only lasts for about 30 seconds and then the feeling goes away, but during that period of time, gee, I have a great desire to pull the clothing off. / It is a distraction, yeah, and sometimes I think your power of concentration sometimes goes. /

She then describes how she tries to ignore the sensations she is experiencing while wondering what people are thinking.

/I just try and stay reasonably sort of calm and just sort of let it go. Where I do find it a little bit difficult is if I'm in the middle of a meeting or I've got staff that work with me and we are sitting in a meeting and I can feel this happening and I just try to as much as possible just sort of ignore it and just continue on, but sometimes it is a bit difficult and I do think what are the other people thinking that are in the meeting or something with me? So, from that perspective, not so much embarrassment, but I do feel a little uncomfortable...../.....focused on what is actually happening to your body./

Two leaders discussed their concerns regarding the possibility of others *misinterpreting* their physical response to a hot flush (sweating, flushing or apparent discomfort) as nervousness or a negative or unfavourable response to an issue under discussion.

/..... often our board meetings were making decisions about funding, and you would be sitting there and you are quite calm about the conversation that was occurring, but there you would be sitting and going red and sweating and they are thinking, 'Oh (participant's name) doesn't agree with us on this decision. Isn't that interesting?' /And they would say, 'so, (participant's name), despite what you think, we are going to make this decision.' And you would think, 'I don't disagree with you' but there you are sweating and red in the face. The body language was telling them otherwise, or I would be looking so black in the face, so black and tense and black, just sort of getting through the pain or whatever I was having, that they would be thinking, 'Oh gosh,(participant's name) doesn't approve of this decision again'..... and it wasn't associated with that at all. It was just you just trying to..... /

/ At times when I'm sitting up at a table where it is very official and I'm about to present a talk or something like that, then I get a bit self-conscious about the fact that I'm going bright red or I feel that I'm going bright red, whereas I probably aren't, because I can't see myself, but I get very hot then. And some people will then misinterpret that as me being nervous, whereas I'm not nervous when I speak, but I get hot. So I find that it is only when I'm doing public speaking that I feel at all self-conscious about it. /

Although working provided a distraction for one leader, the air-conditioned environment of the office exacerbated her hot flushes.

/ I also think that probably working sort of full-time my days are occupied with other things, so I'm not sort of dwelling on it. The only thing is I do find that probably when I do have hot flushes it does occur much more so in an office environment when you are in air-conditioning. If I'm at home on the weekend I rarely ever have one because I'm really active. I'm either out in the garden or I'm out walking or I'm doing things around the house and that activity just dissipates it. /

A number of leaders discussed the strategies they used for managing the fluctuations in body temperature associated with hot flushes or night sweats. Many of these involved changes to the way they dressed or the type of clothing they wore.

/ I take clothes off. //..... I have layers. ... my jacket is taken off all the time now. If I'm going to some function, I will always have a jacket. In the last year I've just not even bothered to take the jacket because I just know that it is going to be off more than it is going to be on. So I've modified slightly what I wear just so I can get the layers off! /

/..... being more sensitive to temperature and to heat and it's wanting to ensure that I've got more control over my environment. The way I manage that is much more layer dressing and those sorts of things. /

/ I rarely wear jumpers without something underneath 'cause I know at some stage I'll have to peel something off. /

/..... having to sort of think about 'what will I wear?' more than I did. I look at some fabrics and I think 'Oh you've got to be kidding' This program I'm doing next week, they said, 'Oh we're providing a shirt and a jacket thing for all of the team members' and I said, 'what use is this for a menopausal woman?'

In addition to changing the way she dressed, one leader had another strategy for keeping cool.

/..... [the] realisation that you only ever wear summer pyjamas these days and that you have to have a foot flapping around outside the bed to try and do some temperature control and those sorts of things. /

Humour was frequently used by women who experienced hot flushes in public situations to reduce their own and other's possible embarrassment.

/.....it [hot flush] happens to me at board meetings. I chair about four committees and, at times, I'm sitting there stripping off. I deal with it by

making a joke of it. I'm very open about it. //I just take it as a huge joke and I laugh and everyone laughs with me. Sometimes people will then turn and admit to it if there are any other women in the room, but blokes.....I just kill myself laughing about it and so it relieves the pressure on them too. //By laughing at myself and stripping off and then putting things back on, I don't care and they don't care then. They get over it. They have all got wives. They have all got people who are going through it. /

/I'm quite comfortable with making probably more of a joke of it 'Oh God, we are going through a hot flush stage' or as my husband refers to it as 'a power surge'. /

One leader who often worked in male-dominated environments said she believed using humour with men helped her and the men involved to feel more comfortable about the issue. She likened this approach to the tactics she might use to *deal with bullies*.

/I used to work almost exclusively in a male domain. I now sit on one board that is all men, about eight men or nine men around the table and me. I have some that are now mixed boards with men and women, and I chair a board that is all women. It is interesting if you make a joke of it, men will cope with it as a joke. It is like how you deal with bullies is you make a joke of it and they back off. I use humour for lots of things and it works pretty well for this as far as I can see. /

She provides further insight into how she would broach the subject with her male colleagues.

/I call them my power surges. I just brush it aside. I say, 'Excuse me! I'm having a power surge.' I just take the jacket off and the men will have a little grin, and then I put the jacket back on and someone might say, 'Oh you are cold again, are you?' So they get used to it and they know me well enough. They can have a little dig back and they know I'm not going to take offence. /

One leader felt she could be open with her younger female colleagues without it being *used against* her.

/..... the colleagues that I work with are predominantly female. Most of them are younger than me but by the same token, you can talk about things and joke and laugh, but in a way that isn't then used against you. /

Another leader who worked in predominantly male environments did not feel she needed to conceal the fact that she was having a hot flush.

/ I worked always with men. So I was always very open about how I was feeling. So if I had hot flushes, I wouldn't have tried to sort of pretend they weren't existing. I would have said, 'This is how I am now.' I would have been quite open about it. /

For other leaders, the degree of openness depended on the situation and who was present.

/ It would have depended who I was meeting with. A lot of the meetings were with outside bodies. It would depend. If it were men that I knew and would manage it, I mean, hopefully I would do it differently now, but then I probably didn't...../

When asked how she thought she had managed at the time:

/ I think I probably would have just sipped on my water and just sat quietly until they [the hot flushes] just went past. I think I have memories of having meetings with other health professionals in meetings where I obviously would say something and everybody would have a bit of a laugh or 'I can't wait until it happens to me' and so on and so forth. I certainly didn't acknowledge it at the meetings with the outside people. /

Other leaders were also more inclined to reveal that they were experiencing a hot flush in certain circumstance but not in others.

/ I wouldn't necessarily say 'Oh gosh I'm having a hot flush!' if I was in a meeting, where as if I was with my women colleagues I'd go 'Oh bloody hell! /

/ I've stopped saying 'is it hot in here or is it just me?' .and they'd all go 'no, no it's not hot in here'. I've decided that this is not a good question to ask. /

/ I would admit sometimes to other women that 'I'm really hot, it must be that time; I'm just going to go and disappear' but only to people that I trusted. /

One leader described her observations about how she would feel and how she thought other people may react when a woman was experiencing a hot flush in a public situation.

/ I always feel a huge amount of empathy because typically the rest of the people in the room would be mainly male and they are not quite sure how to deal with it, but I think most women have dealt with it with quite good humour.//... they have been a bit self-effacing about it and tried to get through the moment. They certainly haven't wanted to draw attention to it, so they have just made a little quip and everyone has got on with it. To the guys' credit, I actually can't think of when guys have sort of squirmed. They just tried to pretend it wasn't happening. /

I mourn the loss of my libido.

Although many participants checked *less sexual feelings* and the majority of participants checked at least one urogenital symptom (*dry vagina; uncomfortable intercourse; urinary frequency; loss of bladder control*), there was little reference made by participants to these issues during the interviews. When prompted, some participants appeared reluctant to enter into discussion about these issues and the subject was not pursued in these circumstances.

One leader expressed her concerns about her declining libido quite simply:

/ I mourn the loss of my libido. /

Another participant who was experiencing problems in her private life was unsure whether her declining libido was in fact due to hormonal changes.

/ I sort of put that down to why I am ticking boxes like depression, less sexual feelings, no feelings, because you are dealing with this very traumatic situation//..... the, less sexual feelings, I mean, I've been married (...) years, so I just assumed that that is all part of that process. //.....the more you lose those feelings, the harder it is to get them back but.....//..... it is a concern I think, but I try and rationalize it, 'Why is it a concern?' It could be environmental reasons more than physical reasons just yet. /

When prompted to discuss having ticked *dry vagina* one leader talked about her *surprise* at the change in her physical responses.

/.....that's [dry vagina], well painful! Just one of those things that I think was, a surprise for me and not something that I'd particularly thought about even though, you know, I'd had the blood test that had said 'oestrogen levels were dropping' and so I knew all of those things were happening..... that came as a bit of a surprise in terms of my body not responding how it had responded in the past. /

One leader questioned whether the problem was stress related.

/ I started using HRT cream, a topical cream, and the reason for that was because I did have a dry vagina at the time, but whether that was caused by the stress, I don't know.//Or whether it was just a stage I was going through or what; but, anyway, she [the doctor] said, 'Use this cream. Don't go putting it up your vagina.' /

Another talked about using over-the-counter products to manage the problem.

/ It's a manageable problem from my point of view. Over the counter stuff from the chemist is fine. It's not something that is causing me a great deal of grief. If it was, then I'd talk to the GP about it because, at the end of the day I'm fine with all of that. /

The problem of *dryness* began *post-menopause* for one leader and had recently caused her to seek medical advice and treatment.

/.....that all happened post-menopause really I think. // I think probably a lot of the things are post-menopause.//When it stopped; all those things like the dryness were certainly part post-menopause.//..... it has happened more recently..... I've been again to see a GP. //.....she certainly prescribed things to help with.....//..... things that help with the moisturizing, keeping it damp. /

Two leaders talked about a change in *urinary frequency*:

/ I found myself in strange cities going, 'So where is the toilet?' And just having that sense. Sometimes I actually ran back to the hotel with this sort of sense that my bladder was full, but it actually wasn't.//..... just really being in this foreign environment made me very anxious of how much I was going to the toilet. /

/ Some days you just think you need to go to the toilet like regularly in terms of passing water and such.....//.....maybe over the last 4 or 5 months, I've noticed some difference and then occasionally it just seems, it can be worse. /

Don't wear white!

Heavy or irregular periods were a source of concern for a number of participants.

One leader described how her periods, which had often been heavy, became even more problematic at the time of perimenopause.

/.....very heavy periods, such terrible periods. I remember having some shockers// I had one really particularly severe time where I had terrible tummy cramps and very, very heavy bleeding.....she [the GP] realised it was part of menopause and put me on the treatment.//I used to have heavy periods, but not these dreadful cramps and muscle pain and bloating and flooding, and all that sort of thing. /

Extended periods of bleeding were attributed to an increase in stress levels for one participant. This reportedly caused her added inconvenience and concern because it meant her GP would insist on her being *screened* in order to eliminate other possible causes of the bleeding.

/..... a couple of times when I was about to go overseas, I would have essentially, periods that would last 6 or 7 weeks, so I'd go and get that checked out and what I worked out in conjunction with the doctors is that it was associated with my stress levels in terms of trying to get everything done and get on a plane 'cause it's like, 'hang on a minute', 'this happened last time I went away'. And so the blood tests came out of a, probably a more thorough screening in terms of 'is something going on here? /

Erratic periods were a concern for a number of participants.

/.....erratic and you just had to have protection on. That was how I felt, because you just never knew quite what was going to happen. /

/ A couple of years ago when my periods were, were finishing and they were very erratic and could be quite heavy..... that in many ways was probably more concerning..... just that whole thing of 'if I've got to be in the (....) room for 3 hours, will I be OK? 'Don't wear white' you know those things. /

/ I'm one of those people where in terms of periods where I could virtually set my watch by them. From the time they started when I was 15, I mean, literally, almost to the time of day, it was just ridiculous. So now they're slightly less predictable, only that I'm not sure which of 3 or 4 days of the week things

might start and they're heavier.//I guess it's heavy enough that if I was in a meeting that ran more than a couple of hours, it would probably.....I'd start to worry...../

Irritable, anxious and feeling low.

Many leaders reported an increase in their experience of *irritability* and *mood swings*. One participant likened the experience to the changes that would be associated with the menstrual cycle.

/ I think, irritable, probably mood swings, the things that really we would probably attribute to hormonal before our period and that sort of thing. /

Another participant reported that she had not associated her mood swings with perimenopause at the time when they had occurred, but had attributed her behaviour to the demands of her everyday life.

/ I certainly wouldn't have gone to the doctor and said, 'Look, I've got this irritability and mood swings.' I probably would have put it down to trying to manage family, house, work, and all of that. /I would think I probably excused it in those ways. /

Interrupted sleep patterns reportedly affected one participant's mood. She also noticed that she was less tolerant than she had been and believed that her family may have borne the brunt of this change in her temperament.

/ I think the irritability is somewhat to do with the sleep, but I also find a bit older I get, the less patient I get. I was always someone who was able to let things go through to the gatekeeper, and now I just pick everyone up on every little thing. // I have always worked hard. I have always worked full time when the children were small, so I suppose they are used to me just sailing through that and now I'm at the point where I get very grumpy very quickly. /

Similarly, another participant mentioned her concerns that it was her family that bore the brunt of her mood swings and changes in temperament. She believed however, that she was generally able to manage her behaviour while in the workplace.

/ I think as far as the work goes I used to just put on a face and go like mad at work, and then a lot of the irritability and the mood swings and things came out at home. / All of that happened with the family instead of at work, although I'm sure the work colleagues also copped some of the mood swings and things as well, but I don't think it ever was so bad that it affected my work in that people would comment or anything. /

She then describes how the changes in her mood and temperament lasted for some time.

/ I had many years of mood swings. I certainly remember mood swings, going into tempers and things, mostly at home again. I do remember that going on for some time. //..... that last few years. I think that was when it was particularly bad, and the mood swings were particularly bad. /

Travel and being away from home affected one participant's moods.

/..... when I think back on it, I noticed, for example, if I travelled away from the home situation, you would notice the irritability and shortness on travel, the mood swings. /

Having an interrupted nights sleep and a busy schedule contributed to one participant's irritability.

/ I think that [disrupted sleep] does lead to some of the irritability, because by the time I'm cooking dinner at 7.30 or 8.00 o'clock at night, I have been up, well, sometimes since 3.00. /

A lack of awareness about the cause of her symptoms reportedly contributed to one leader's inability to manage the situation effectively.

/..... irritability. This bit about irritability, unloved feelings, mood swings. I think I've sort of put really, all into one, and that was the bit that..... I don't think I managed well 'cause I didn't recognise what was happening. /

In contrast to the experience of others, one leader said she felt she had fewer mood swings in the absence of her normal monthly cycle.

/ I certainly don't feel as though there has been any real change in moods or anything like that. My husband might think differently; I don't know. But I don't necessarily feel it. If anything, I think the moods are probably more balanced because the hormonal sides of things with the swinging are not quite there with the cycle. /

Although a number of participants checked *anxiety*, not all chose to raise the issue during the interview. None indicated that they were certain about the cause of this symptom although all had noted a change in the way they experienced anxiety.

/ The anxiety. I do remember the anxiety and the first anxiety attack I had. Whether it was to do with menopause or not, I don't know. It started out feeling contented and pleasurable, and it was as though something in my brain said, 'Well, we can't have that, can we?' Bang! And I would get this anxiety attack. /

/ I worked with (company name) who was dreadful with its women, and it was so hard on me. That pushed me into being anxious anyway. I had no peers I could relate to and all that sort of thing. So I wasn't a natural presenter and those sorts of things, so any anxiety I did feel would have aggravated the anxiety that people knew I felt and therefore I wouldn't have discussed it. I would have been shy about it, because it would have gotten worse than usual. /

/ I seem to get much more anxious these days, and I notice the anxiety on things like your driving is not as good. I'm a cyclist, and I'm really spooked now by cycling. I'm so un-brave, you wouldn't believe it. /

A number of participants noted *depression* on the checklist. One professed to being

uncertain about what constitutes depression and to what extent her symptoms were related to hormonal fluctuations.

/ I have had times where I've just been a bundle of tears, but it is not often at work. It has to be fairly significant. // The sadness is probably the thing that would be the one that would most.....//..... depression, I assume I am depressed at times. I mean, I haven't been clinically diagnosed, but there are times when I find it just really, I just..... I don't know what depression is, to be honest with you. I have ticked the box, but, you know, at a point where I just don't want to talk to anybody. I just feel really low, and I'm not that kind of person. I mean, I'm in (a public role) for God's sake! But I do feel downtrodden a little bit with my home situation, yeah, so I'm assuming it must be depression. Now, whether that is linked to hormones, it quite well.....And I certainly know mid-cycle now, two weeks out from my period, I want to kill somebody. /

Another described how her mood could change suddenly and without warning. She also described feeling less *happy and content* around perimenopause.

/ It was a lovely day, the sun, the birds, and I was thinking, 'God, this is good' and Bang! I thought, 'Where did that come from?' // I would wake up in the morning feeling somewhere below baseline in terms of feeling happy and content and everything. /

Two other leaders reflected on how they had experienced feeling *low* and how this had been the catalyst for using HRT.

/ I don't normally feel low. I wouldn't say depressed, but low. I kind of wake up in the morning and I'm bright and I'm kind of chirpy. I can remember driving to work and thinking, 'Oh gosh, I feel low.' It was that kind of feeling. // I don't know how long that went on for, but I think it was probably quite a while. I mean it might have been, I don't know, nine months or maybe even close to a year, but just that sort of low feeling. /

She went on to talk about how a conversation with a female friend subsequently lead to her use HRT to alleviate her low mood.

/..... we were talking about the menopause and the changes and our feelings and this feeling of lowness, and she said, 'Look, I went onto hormone replacement therapy and the very next day I woke up and I felt different. I felt back to my old self.' I don't know whether it was because she implanted that idea in my mind that I was going to do it too, but it happened.// So that was my experience and that certainly lifted the depression- that depressed feeling...../

The other leader described her *low* feelings as resembling *permanent* PMT.

/ I had these symptoms which were, I don't know, feeling low, teary. I would like to say depressed, elements of depression, but you don't even know what really. You are just feeling like PMT, like permanent PMT. That's how I remember describing it. /

Having a disrupted night's sleep due to a skin irritation (which she later attributed to perimenopause) while trying to cope with the demands of young children caused one leader to feel depressed.

/ ... that can bring on a lot of depression because I would be walking the floor scratching myself and thinking: 'it's day light and the first little person [child] in my life is going to be awake soon. How are we going to get through this day?' /

Another leader attributed *strange* and *emotional* feelings to having had a hysterectomy.

/ I was feeling strange, teary and all of those sorts of emotional feelings and I assumed that was because I had had a hysterectomy, because the only thing I knew about a hysterectomy was the word came from hysteria which meant 'Oh my God! I'm feel I'm not a woman anymore, I'm going a bit sad' and so on. So that's what I assumed. /

Two participants noted having *unloved feelings*. Both talked about having been unaware of these feelings at the time and only able to recognise the experience retrospectively.

/.....the bits that I didn't, that I don't think I picked up were, a little bit of feeling unloved and a little bit of mood swings...../

For one woman, this recognition only came about when she undertook HRT and things improved for her.

*/ I was feeling very unloved and overburdened, unnecessarily I thought. /
/.....one of the things I noticed most in that relationship was that I was trying to blame him [her husband] for me feeling down..... that sort of 'well it's his fault' and unloved and I just thought then afterwards, 'how unfair' when things improved for me. /*

A bit more forgetful and less on the ball.

Although a number of leaders indicated that they had noticed changes in memory or concentration, there was often uncertainty about whether these changes could be attributed to hormonal fluctuations.

One put her *loss of memory* down to being *slack*.

/ I seem to have loss of memory, but who knows why, whether it was just because I am slack. /

Another blamed her forgetfulness on her age.

/ I guess at my age, I mean we all forget things and sometimes I get bothered by thinking now, 'what was that person's name?' and I'm driving home from a function and I think, 'yes well of course, that's his name.' /

Forgetting a particular word was frustrating for one participant.

/.....and that's more, just frustrating when you, just sort of stop for a moment and you might just forget that particular word that you were actually going to say and then just come back to it a second later of something, but it's just glimpse of 'oh gee, what was I going to say?' /.

Writing things down helped one leader cope with her memory lapses.

/ I find that I'm a little bit more forgetful and I have to be really conscious of writing things down. or I will have a conversation with somebody and then have to think about what the conversation was five or six days ago, and I'm thinking, 'Oh, what was it that was discussed?' and I have to really think it through probably more so than it just coming to mind quickly. I don't know whether I can attribute that to menopause or whether it is just the ageing process overall. /

She related her experiences of working with younger people and finding that she did not perform as well as they did. She again questioned whether this was related to menopause or ageing.

/..... in terms of concentration, I was less on the ball, particularly when I was doing my Masters and doing it in group exercises with people who were considerably younger than me, probably 20 years younger. I think it would take me probably longer to actually sort of think things through and get on top of it and so forth than someone who was 30 or 35 or even 40. // I probably had to put a little bit more thought and effort and so forth into it, but whether that is just menopause or whether it is the ageing process...../

One leader however, provided a very descriptive account of changes in her cognitive function which she confidently attributed to perimenopause.

/.....in that period, those couple of years, I couldn't think. My brain was..... I always used to say when I had bad PMT it was like there was a magnet pulling at my brain. That was the feeling that I used to have, through that PMT and

through that menopause bit untreated, that's how it felt, permanently like that. Therefore, with this happening it was just full. There was no room for thought. I could function, but I couldn't think. //..... in fact I would say there was no strategic thinking. /

Erratic, loony and emotionally driven extreme behaviour.

A number of participants mentioned symptoms that they believed were associated with perimenopause that were not specifically mentioned on the checklist. These symptoms were often reportedly related to changes in emotional reactions that the participant considered uncharacteristic. Frequently participants said that they only gained insight into the change in their behaviour retrospectively.

One leader described her reactions and behaviour around this time as *erratic* and reflected on her lack of insight at the time.

/I don't think I recognised at the time it's only in retrospect that I sort of see things and the most particular element of that was I think I was much more erratic, emotionally erratic and..... it's only now, or some years after all that happened I thought, 'crickey! I was all over the place about how I was feeling/..... in particular some erratic behaviour around a particular male at the time which when I look back on it, 'why was I behaving like that? Why was I feeling like that?' because I didn't recognise at the time that it was connected to my sort of stage in life. It was just so sort of un me about the way that I was, behaving / I think it was some years later that I was able to think, 'Oh GodI think that's probably why.....' I think that impacted on my life more than anything. I'd also say that, at the time that I had the most symptoms, I was the general manager of (company). /

She talked further about how useful it may have been if someone had been able to draw her attention to the change in her behaviour at the time it was occurring.

/..... it's only now when I look back and think 'God that was very erratic

behaviour' and I'm not really erratic, normally, and I really was erratic, up and down and all over the place. So whether it got better or not, I don't think I knew that there was something that needed to get better.//I suppose, if I could wind the clock back it would have been helpful if somebody had been able to put a mirror up in front of me and say, 'hey, you're, this seems like, it doesn't seem like you, do you think it could have anything to do with menopause?' and I think that might have stopped me in my tracks to think, 'wow! That isn't like me.'/

Others also noticed more subtle changes in their emotional response to situations during this time.

/I mean it wasn't horrendous, or I wasn't flying high one minute and in the depths of despair the next. I was just very much, a lot more emotional, cry easily and do a little bit of poor (name) occasionally I've had a few 'poor (name) days', during that period. /

One leader described her behaviour at the time of perimenopause as *loony*.

/.....my major symptoms were all emotionally related. And that was at the same time that I had just been promoted to be a board director of a large (.....) company. So the two things came together. Well, in fact, the first phase came when I was just promoted to be a manager of a division and then I was well and truly realising I was half loony by the time I was made to be a board director. P8/ I think what I mean is I was literally loony. /

She related an incident which she believed demonstrated how aberrant her behaviour had become.

/I walked in there [the doctor's surgery] and I picked my ticket up and I turned around and said to those women, to everybody there, 'You may think your ticket is taking you in before me, but I am going before all of you, otherwise I'm going to be hanging from the rafters!' And they all just put their heads down and people let me go in and I was the next one in, even though they were

all before me. So, you know, that's how loony, because I really felt like I could jump off a bridge, type thing. /

She continues with other descriptions of what she calls her *emotionally driven extreme behaviour*.

/ I would do one of two things: I would cry or if I felt really strongly about something I would shout and scream.// Yes, the permanent PMT state, you know, totally irrational and a bitch. // Yeah, I think that is exactly it, extremes, you know, emotionally driven extreme behaviour. /

Another participant attributed her loss of *courage* to hormonal changes.

/ I have lost my courage and all that sort of thing, and I'm sure that is hormonal. I'm sure I haven't got quite such a wimp just because I've got old. /

Two participants talked about how other people were able to recognise the change in their behaviour at the time it occurred and were able to reflect on this at a later date.

/ I certainly was known; colleagues would tell me, as quite, not ferocious, but certainly quite determined and quite dogged at work, black was black with me and white was white and never a dot of grey. I'm sure that was all part of this, 'I've got to get through the day.' /

/ One particular friend still makes remarks when she meets friends of mine, 'Oh, you want to see what she was like at that time.' But what she always says is that I was totally demanding and could go hysterical, scream and yell and rant and rave, but it was never personal...../

The same leader reflected on how she believed she managed to deal with issues at the time albeit somewhat *irrationally*.

/ So, you know, there is an element of you, of me, or of one that you can still keep your.....There is a line that you still don't go over. Actually, I probably

wanted to tell them they were useless or whatever, but I dealt with the issues still even though I did it irrationally or, you know, over the top. /

Another leader also talked about being less rational at the time and described how she managed to minimise the affect of this in her interactions with others.

/I kept my workload down to a minimum and my contact with people down to a minimum, so that I knew that I was stable when I was talking to people, because I found that I wasn't quite as rational. /

One participant questioned whether her decision to leave her job was related to hormonal fluctuations that she had not recognised at the time.

/..... the general thought of 'I'm going to leave all this' was such a relief, and I wonder if that was because of the hormonal stuff. I really do. I mean I used to enjoy my work and I enjoyed it to the end because it was stimulating, and I still like mixing with stimulating people and that sort of thing, but, you know, the thought of all this managing all these people. Perhaps blokes get fed up with it as well, I don't know. /

After initiating HRT, one leader said she was able to reflect back on her pre HRT behaviour.

/ I really noticed it, [the change in behaviour following HRT] but no one ever said because they didn't know what was happening. I think the board of directors was very pleased with me and I think their view was that I grew into the role. That's what they used to say, 'Oh, you've really grown into this role' whereas, they never referred back to 'you know you were a blabbering idiot.' But I can remember the manager saying to me once in one of these situations where I was beside myself, 'You are so mercurial of mind; this idea one day and that the next.' I can remember thinking, 'Mm, mercurial of mind, well, that is not me. Usually I've got my view and that is it.' I didn't react to it; I just remember thinking, because he was right. /

For one leader, a lack of insight into the possible role of fluctuating hormones as the cause of a change in her behaviour was seen as a possible factor in her marriage breakup.

/.....my marriage also broke up around that time. He was a lovely man, but retrospectively I totally realise it was this whole thing..... I was a pain in the arse to live with and I didn't understand and he didn't understand and no one ever told us anything. So we didn't even know that..... Luckily, five or six or seven years later we ran into each other and had a little chat about it and realised, both of us, that that was what it was. So, that was all in that whirlwind thing happening, the permanent PMT state, you know, totally irrational and a bitch. // I definitely am a hormone affected person, HAP. That could be a new acronym, couldn't it? /

Superordinate Theme Two: Soldiering On or Taking Control

Participants chose different strategies to manage perimenopausal symptoms. In many cases, leaders indicated that their decisions to either *soldier on* or to *take control* of symptoms reflected their general philosophical approach to managing difficult issues encountered within their personal or professional lives. Attitudes to perimenopause and the use of *medication* also reportedly influenced decisions about treatment options. Participants, who chose to *soldier on*, often reported using behavioural strategies, lifestyle changes and *natural* approaches to symptom management. Others indicated a preference for *taking control* of their symptoms, with some choosing interventions such as medically prescribed hormone therapy.

Just get on with it!

A number of leaders described a *just get on with it* approach to their management of symptoms.

/ Depression, mood swings, some people go along like this. I'm not one of those people. /

/ I probably have quite a strong work ethic and just sort of get on with things and life is very much in that sort of mould. /

/ I have sort of been the achiever. I have always pushed myself out of my comfort zone, so it is a matter of just getting on with it and dealing with it. So that is my personality. /

/ I haven't found anything I didn't feel I couldn't manage. I'm a very sort of mind over matter type person. /

/ I've got a pretty, pragmatic approach...../

/ I mean, I think I'm sort of a, 'get on with it' sort of a person.// 'No nonsense, get on with it', and I'm sort of a bit like that even now, you know, 'just get on with it'. /

/ I think as far as the work goes I used to just put on a face and go like mad at work, and then a lot of the irritability and the mood swings and things came out at home..... /

/ I probably fairly actively manage a fair bit of that stuff, so if I do think 'I'm feeling anxious' I'll actually work through and I'll say ' Well OK. What's happening? Why? What do I need to do about it?' /

One leader's belief in herself as a *motivated person* caused her to hesitate in regard to seeking professional advice about symptoms.

/ I have thought seriously about going to someone and I have actually made some enquiries, but I'm not at the point yet where I have done that, and I suppose the reason I haven't is because, you know, going in and trying to

explain it all, and I keep thinking to myself, 'You are a motivated person; you can get a handle on this and do it yourself.' /

Another leader's sense of professionalism reportedly motivated her to avoid taking *sickies* even when she wanted to *run away*.

/ In my work place I am very professional and kind of separate myself mentally, I think. So I haven't had issues where I have been a cot case and had to take days off and so forth. I have wanted to run away at times, but I think because I'm so disciplined in my work place that I don't take sickies...../

A positive outlook about ageing reportedly motivated another leader to *survive wonderfully* during perimenopause.

/ Look, I think part of it is just that whole issue of ageing, and my thing has always been that you should look after your health and, you know, survive wonderfully./

A number of leaders talked about how their determination to cope during this time often had ramifications for themselves and others.

One leader described how she was determined to *push through* her symptoms until she realised she could get help.

/ I mean, with all three roles, you can't have off days.//.....you get really busy and so engrossed in what you are doing or trying to achieve or whatever, and you just keep pushing and you think you can push through these things, and then sometimes you realise you can get help. /

Another leader reflected on how she later recognised that she had become more *matter of fact* about things at that time of her life. She also talked about her determination and how she *pushed* herself through things.

/ I think I became more matter of fact about my work and things. I didn't spend a lot of time on the social interactions and those sorts of things. I really just got into my work and just got it done because I had to get it done.....//Whether that was work or the situation or whether it is to do with this [perimenopause] as well, I'm not sure, but certainly.....//It was around that time that I sort of had a sense that I was certainly a lot more matter of fact about my work//..... again I think that is part of my personality in a way in that I'm very determined to do things.//I pushed myself through things...// I was always very organised at work. I always made sure I was well prepared before I went into things, so that I had a back-up if I didn't feel so good.....//Rightly or wrongly that was the way I dealt with it. /

She also talked about how she believed that she lost a lot of the *softness* during the time when she was experiencing symptoms. She described how she would *hang in there* in order to manage certain situations.

/ Hang in there and just get through it'. I'm sure that was all sort of a part of that because a lot of the softness went during that period, I think. In retrospect, I'm sure a lot was the result of the sweats, because you just had to do a job and you had to get on with it and you had to sit in board meetings, which we had all the time at (organisation), and feeling lousy but you had to sit there and get through it. So you just gritted your teeth and got on with it. //..... you would just do it, heavy flooding and all the rest, you just keep going...../

One woman reportedly preferred to discuss her concerns with her husband rather than *bring it into the workplace*.

/ I wouldn't bring it into the work place. I think probably what I did was I would have done a lot of talking to my husband and gone through a lot of the work place issues with him to try to work out solutions or ways forward. If you ask some of the staff, they might see it quite differently, but I don't think that it affected the way I managed, although, you know, I certainly do recall having hot flushes in meetings and that kind of thing. /

When asked how she recalled managing having a hot flush during a meeting:

/ I think I probably would have just sipped on my water and just sat quietly until they [hot flushes] just went past. /

A number of participants talked about the strategies they employed to maintain their health and well-being in order to ameliorate their symptoms.

Despite a very busy work schedule, exercising and maintaining an active social life helped one leader cope with symptoms.

/ I exercise. I go to a personal trainer. Most weeks I go 3 times a week. I walk on the weekend. I really work hard at ensuring I've got a good social life so that sometimes means that I don't have any nights home at all and I'm involved in a community group as well.// a lot of that is really deliberate in terms of a way of making sure that there's some balance; that it does help you deal with stress because you're having a different set of conversations.....// I'm passionate about work. I've worked crazy hours and I could easily work more crazy hours. //..... it's about finding ways of breaking up those things and staying connected with people who are really important in my life//..... making sure my husband and I go out for dinner and do those sorts of things are also part, for me, of just managing it all. /

Maintaining a healthy lifestyle reportedly helped one leader avoid the *need to go on medication*.

/ I don't take anything for menopause and I try to be very active. I'm a person that exercises quite a lot. // I eat a huge amount of vegetables and exercise and everything, so that is my way of managing it. To date, I feel as though it really hasn't impacted on my life to such an extent that I need to go on medication. /

Another leader believed that yoga and exercise helped her to maintain a healthy mind and manage her demanding role.

/ I do yoga. //..... and I mean certainly some of the yoga assists with the menopause.....//..... and I do a lot of walking and am just pretty active, so I just try to manage it in that sense. I think by doing that and having a healthy body, I think that sort of contributes to having a healthy mind which helps me manage the workload, because it is quite a demanding role and I do work quite long hours. /

Time out.

For a number of participants, their executive roles enabled them to be more flexible in their work arrangements and to use this as a means of coping with or managing certain symptoms.

/.....it is a very flexible job in that sense..... if I do wake up one day and feel crappy, 'Oh, I'll work from home for a couple of hours' if I haven't got any meetings on that's fine. . //.....and there's no one going 'Where were you? Why weren't you in.....?'. and 'This is not good enough. It's just not the way it works.' /

/ I negotiated a nine-day fortnight, a new contract, and I think that was my way of saying, 'Hello, I just need one day in a fortnight of my own', and 'of my own'. /

For another leader, this sort of flexibility was not always an option.

/..... there are times when you can hide away a little bit, or just not schedule meetings for that day if you have got that flexibility and also it is an environment where it is quite a younger person's profession to work in./ So, you have got to be fairly active and on-the-ball to be able to manage...../

One leader described how she would take some time out so she wouldn't have to *test the waters*.

/ I think that when I felt the hot flush coming I would then think, 'something is going on; okay, let's have some time out.' And so I would just take some time out. So I wouldn't put myself in the situation. So I never really had to test the waters. // I just accept that you have your good days and your bad days, but when you have your bad days, you rebook your appointments. /

Seeking support.

A number of participants actively sought information, advice and support as a way of coping with their symptoms. The degree to which leaders chose to or felt able to discuss symptoms with significant others varied. Some found advice and support from relatives, friends, colleagues and medical professionals helpful. One leader made a general comment about her attitude to seeking and sharing information.

/ My background is science and being fairly open about.....I know some women don't like to talk about anything that's personal and those sorts of things, well, I'm not one of those. I'll ask questions, or someone's read something so I'll read that or talk about it. I'm quite open to sharing information. /

A number of participants found talking with friends or family members was a source of both support and information.

/.....friends all around the same group all tend to talk about it and I think the friends network was really important and I have a number of friends who are older than me and that was helpful, that was actually very helpful...../

/..... this group is a menopausal support group, that's what we call ourselves, and really going along to groups like that can really help.//..... it gives you the idea that you are not the only person to experience these various symptoms or to be in that position.//..... and probably my sisters, they probably prompted me. We researched it, we talked. /

The experience shared by a friend alerted one leader to the possible cause of symptoms she had been experiencing.

/ She had obviously gone through the menopause at that stage. She was working at the time and she had said what her symptoms were. She had obviously been to her doctor and got the HRT. So I kind of just knew that that was exactly what was happening to me. So I went to my doctor and I said, 'I think I've got pre-menopause or menopausal.....' /

She went on to describe her relationship with a group of peers who provided advice and support to each other throughout the time of perimenopause.

/ I've got this group of friends, a group of women, who I don't see very often. Maybe three or four times a year we go out for dinner together. We call ourselves the MSGs, the menopause support group. It is just a little joke. We have been doing this for probably about 15 or 20 years, the MSGs! /

Another participant discussed the impact of skin rashes that she experienced at the time and her realization, after talking to friends, that the problem may have been related to hormonal changes.

/.....one of the things that nearly drove me over the edge was around that time I obviously had a major hormonal change, 'cause I came out in enormous rashes , allergies to what the doctors thought it was to dyes in fabric, but I had spoken to a couple of other friends who had been put on particular drugs for that sort of thing and they said 'you know have you ever considered that it's got to do with the change of life?'and I just wonder in retrospect, how many creams I've put on my skin and what ever, cortisone, when it may have been...../

Another leader also talked about the value of talking to other women who were of a similar age and educational level.

/ I talk to girlfriends. we have been meeting together for so many years; we talk about 'the change'. //.....we were all talking about the change and what to do and this, that and the other. /..... 'what colour are your tablets? / That was when we were all turning 50 //..... that group were all, if not academic, well educated, rational thinkers. /

One leader, who had acknowledged that she was in early perimenopause, said that seeking information was not a priority. She indicated that she would deal with problematic symptoms when and if they arose and would then seek advice from friends.

/ I guess in some ways, it's probably..... a little like when you're pre-adolescent, you know that it's coming and you kind of think 'oh well, what's it all about?' but until you actually hit it.....//..... I'd probably chat to some of my friends about it as well; find out what they've done. /

A number of leaders discussed the pros and cons of seeking advice and support from colleagues. One leader described how discussion with female colleagues did occur but was often limited to a fairly brief and superficial exchange of information and a show of empathy.

/.....it wasn't talked about consciously.//.....we would talk about it but just have a joke about it and not say, 'Are you seeing a doctor? Have you tried this?' It wouldn't get to that depth. It was just the, 'Oh gosh! Are you going through that too? You poor thing!' That would be the sort of extent of it in a way. /

One leader reflected on how things had changed in the time since she'd experienced hot flushes at work. She believed it was now much easier to talk about.

/.....someone's always saying 'Oh, excuse me; I'm having a hot flush' it doesn't matter if there's men there or anything//somebody will say, 'OH God! Hot flush! Hot flush!'..... it's much easier to talk about it, it's also, sort of ten years on too so it's a bit easier to talk about those things, but when I was working with a young group, it wasn't talked about. /

Another said she would talk to those in her own age bracket, but that she did not think younger women would be able to relate to the issue.

/ The girls in my particular department are all in their 20s or early 30s, so they probably don't relate. They just think, 'Oh gosh, she is getting old.' So I wouldn't necessarily discuss it with them, but certainly people around the same age bracket. /

Another leader believed women colleagues would generally be supportive of each other.

/ I think most, nearly all the women who work here would have other women here that they can talk to and some of us would have a lot of those women in common.....so there's that sort of, quite collegial caring..... even where there's not necessarily a, like a strong friendship, some of us catch up very regularly 'cause there's a strong friendship as well. /

A number of leaders also discussed talking to family members and friends about perimenopausal symptoms.

One talked about the resistance she had experienced when trying to advise her sister about managing perimenopausal symptoms.

/ I suggested to her HRT but she was negative, feeling depressed and putting the blame on her husband for all the ills and what ever in the family...../

Another leader who had had a positive experience of using HRT was quite forthright in her advice to a friend.

/..... she is still not sleeping and this has been going on for years. I said to her, 'Why don't you go on HRT?' 'Oh it's dangerous.' I said, 'No bloody way!' you know. I said, 'And even if it does mean you are going to drop off the perch a few years earlier, at least you had a good time and can go out roaring.' /

I like my doctor.

The relationship leaders had with their doctor or health professional often appeared to be a factor in regard to their knowledge about and attitudes to perimenopausal symptoms and treatments. A number of topics were discussed including how comfortable they felt discussing certain issues; whether information or advice was offered unsolicited and the nature of the advice given.

Many leaders said they felt comfortable about talking to their GP and confident that the advice given would be appropriate.

/I'm comfortable with her. She seems competent, so I'd probably rely on her advice to quite a great extent.....//..... she [the GP] will actually ask 'Are your periods still regular?', when I go through the yearly check up//..... if she thinks it's normal, I've only got my experience to go on where as, she's got hundreds of people to compare with so if she was concerned, then I'd think 'Oh well - there's something unusual'. /

/I like my doctor and I've got a lot of confidence in her so if she thought it [HRT] was a good idea I'd probably give it a go and she's the kind of person who would probably want to monitor how things were going and see if that was a suitable treatment or not. /

/I had a very good female doctor who has unfortunately resigned from that practice but she was very good in terms of, good level of care, easy to talk to...../

/..... she was a very good women's doctor who always was running late because you would go in and she would spend time with you. /.....when she talks HRT you would have a long talk about it. /..... you knew that you were getting good education and you were going to be considered and your feelings were going to be considered, and you had a say...../

Although not recommended as a means of ascertaining menopausal status (AMS, 2010 d), a number of leaders talked about their doctor ordering blood testing in response to their seeking advice regarding symptoms.

One sought advice regarding heavy and erratic periods and was offered *hormone tests* and subsequently prescribed HRT.

/ I put up with that for a while and then went to see my doctor, a gynaecologist or whatever/ I had to have some tests. They do the hormone tests and then I was prescribed hormone replacement therapy, which I was on for ages. /

/ I was menstruating, and I had to wait for that to stop before they would do any tests. I don't think it was done light-heartedly. It was done with a bit of caution...../

Another leader talked about being concerned that certain symptoms may have heralded the return of the chronic fatigue she had experienced some years before. She described how her doctor ordered blood tests in order able to alleviate her concerns.

/.....she did blood tests and hormonal level checks and all that sort of stuff and it all came back perfectly. /

In contrast, another leader who sought medical advice because of concern about her symptoms was informed that the tests were not to ascertain her menopausal status, but to rule out other possible causes of her symptoms.

/ ... 'is this associated with changing hormone level and stress? Is there something more sinister that's happening underneath here that we need to be worried about?' So it was in that context that I had the blood tests rather than, 'Am I menopausal or perimenopausal? /

The offer of antidepressants after seeking medical advice for low mood was rejected by one participant who said she preferred alternative therapies.

/.....she [the doctor] asked did I want antidepressants and I said, 'No' and that was it. We left it at that. I sought alternative therapies. /

When her female doctor was replaced by a male GP, one participant found she was less comfortable about discussing some things with him.

/I've not talked to the doctors, mainly because the female doctor has gone and the guy who's now my GP is someone that I worked with. We worked really well together and I trust him implicitly as a doctor but I don't need to discuss some things with him. /

Although she was experiencing symptoms, one leader had not raised the issue with her doctor.

/..... the doctor that I had been going to for many years retired. The one that I've seen since, no, I really haven't sort of...../

When asked if her new GP had raised the issue:

/No, no, not at all. /

Another leader who had been complaining about her waning libido was not satisfied with her doctor's explanation and mentioned her intentions to have the issue clarified at her next visit.

/I will ask her because I have been whingeing about this. She [the GP] says, 'Oh, here is the graph. You are no longer meant to have babies, so you are not meant to feel sexy at all.'/

After experiencing certain urogenital symptoms, another leader was encouraged to continue using medication to alleviate the problem and prevent other problems from developing.

/I went to a doctor a few weeks back and said, 'Should I be discontinuing this?' She said, 'That will stop you from getting incontinence and vaginitis and other infections. /

The importance of establishing a good relationship with a woman doctor was highlighted by one participant.

/ I think if women can set up that sort of relationship with a woman doctor and I say a woman doctor because I think it's far more difficult to do with a male doctor. /

One leader talked about her frustration after getting what she believed was unsatisfactory advice from a number of doctors.

/ I was going to the doctors first and they were saying, 'No, nothing wrong' and then I'm thinking, 'Oh I can't handle the job obviously'. //.....so various doctors, 'Yes, no darling you are alright. That's okay, do you want some pills? No, I don't want any pills. I just don't feel right.' / On the same day I went to three doctors. /

She described how she subsequently searched for information at the library

/ I went to the library, then I came across all these things and these symptoms and this menopause thing, 'My God! That's what it is.' And I understood. I thought, 'Okay, fine, I've got one ovary. That ovary has packed up. I'm now menopausal.' I understood! /

She then went back to see her doctor:

/ I told her what was wrong, what had happened and what I had identified and she said, 'No, no, you are too young.' / All day I spent going to doctors. In the end the last doctor said, 'Okay, I see what you mean. Yeah, we will have to put you on HRT' and then that whole process started...../

More recently, she found that seeking advice about the *pros and cons* of whether to continue using HRT was also problematic.

/ it depends which doctor you see. I had asked doctors every time I go, 'What do you think? Do you think I'm still okay? I would get one who would go, 'Well, you know, you should be off it now. How long have you been on it? Oh dear!' And then you would get the other one say, 'Yeah, look, you know, the latest thing is, I read something the other day and says, dah-de-dah-de and these are the pros and these are the cons.' You know, that's fine, pros and the cons and let me make a decision. /

I just don't like taking tablets.

A number of factors reportedly influenced participant's decisions regarding treatment options. For some their decisions reflected an underlying philosophy about the use of pharmacological or naturopathic approaches while others professed to being prepared to make decisions based on what they considered important at that particular time in their lives. Attitudes and beliefs about HRT as well as advice from significant others also influenced decisions regarding treatment options.

One leader expressed her view that perimenopause is *a natural process*.

/.....for me it was just a matter of this is a natural process and you live through it.//..... and also just an understanding that it is a process that you go through and having gone through it. //..... move out the other end without continuing it or extending it by strategies to try and avoid it. /

For many participants, decisions about treatment reflected existing attitudes to using *medications*.

/ I'm not great on taking things; I'm terrible. I'm notoriously bad to take things. I just don't like putting myself on lots of, you know things. I mean, now I'm on high blood pressure tablets and I have to take them, so I do take them, but if it was anything else I probably wouldn't take them because I //I just don't like taking tablets...../

/ I mean, I'm certainly not hippie-ish in any way, but I think I really pride myself on the fact that I'm not taking any medications..... my first preference I think would be what lifestyle and dietary changes I could make and then is there any sort of herbal or vitamin/mineral based thing, and then I think I would look at HRT. I would always have all the options explained to me, but knowing how I've dealt with other things, even something like chronic fatigue, that is the sort of hierarchy I went through. /

Others expressed a similar philosophy to the use of medications.

/ Well, given that I have taken nothing, I probably would be going down the road of trying to avoid that; very much so. /

/ I only take medication when I really have to. /

One leader specifically discussed her concerns about HRT, the factors that had influenced her decision not to use this type of treatment and her determination to just ride it out.

/ I would go onto HRT with a great deal of caution. // I think this is something that occurs naturally and it happens for a reason. Maybe we don't understand what that reason properly is, but it is the reason our systems have evolved to that point. I'm a great evolutionist and I think the equation can't be that wrong. And so I would prefer to ride it out if I can, anyway. // I am not interested in HRT mainly because I don't want another set of drugs to complicate my current regime. My regime [for a pre-existing condition] works really well and I've been very stable on that regime, so I don't want to throw anything more into the system. So I decided that I would try to just ride it out. And it hasn't been bad enough; if it got really bad, then I might. /

She describes how her decision not to use HRT was based on medical advice.

/I have an endocrinologist for my [pre-existing condition], so I had some discussions with him on HRT and we agreed that I wouldn't do anything about it. /

One leader's decision to avoid using HRT was based on her assessment of the literature she had read on the topic.

/..... having read literature and so forth on it [HRT] I would prefer where possible to just have a healthy diet and keep the exercise up and try to manage it as much as I can and just see if I can manage my way through it than go on sort of medication with the potential risks and things. /

Another commented on her assessment of the WHI study and how the findings supported her thoughts regarding the use of HRT.

/..... that didn't really surprise me [findings of the WHI study]. It is very hard to do population studies that are so controlled that you can come up with, statistics that are meaningful, so I tend to be very skeptical of those sorts of numbers, but there is more and more evidence piling up that excessive use of HRT is, you know, and that doesn't surprise me. You are asking your body to continue with a process that it has had enough of. It doesn't need that any more, and now you are demanding that it continues on. And to be continuing through until you are 60 or 65...../

Having a pragmatic approach to medication appeared to be a factor in one leader's decisions about treatment options.

/I've got a pretty pragmatic approach to medication. If something comes up and I need it I'm not particularly for or against in advance. If, if, you know, if the symptoms were causing me problems, then I'd probably go and see the doctor and see if there's something he can do about it that isn't going to cause something worse..../

Although one leader had heard a number of adverse reports about the use of HRT, she said it was her own experience of having an unpleasant reaction to HRT that influenced her decision to discontinue the treatment.

/ I didn't not take HRT because of the issues from these studies and things. I think if it had helped me I would have taken it and kept going, but I remember taking it and thinking, 'Oh God! I feel like I'm having a period every day with it', sore breasts and...../

Another leader claimed to be informed about HRT and had ongoing concerns about the risks that may be associated with its use.

/ I've read a lot about it. I know a lot about it and I mean the balls out isn't it in regards to how good it is for you, otherwise it can actually be impacting you in other health issues and things...../

A number of leaders talked specifically about their reluctance to use medications or drugs and their preference for using alternative approaches and therapies to manage symptoms.

/ I'm now looking at, herbal, I mean, I have never taken anything medically, anything...../ But I have just, only this week in fact, because I am hopeless at remembering to take things; that is my problem, started taking a few things, like, the Evening Primrose and the fish oil. Whether it makes any difference I have no idea...../

/ I actually take no medication at all and so I am not someone who likes popping pills. So I think I would probably look at alternate natural type of dietary and potentially lifestyle changes before I would look at taking a drug. /

/.....my own way of dealing with things in terms of night sweats and things like that is, I'd take things like evening primrose oil, and black cohosh and those sorts of things as part of the 4000 vitamins I now take to keep my body moving.

I think I would suggest a whole lot of things before I would say, medical intervention, HRT and that's before HRT got a bad name...../

/I decided I was going to not do anything about this. I certainly wasn't going to be taking anything like antidepressants or anything like that./.....she [the GP] asked did I want antidepressants and I said, 'No' and that was it. We left it at that. I sought alternative therapies..... I was taking alternative treatments, which seemed to be okay. //..... going to naturopaths and what have you, and they would make preparations. /

/..... hot flushes started first and that's when I had the homeopathic, and that actually worked really quite well for me the homeopathic.....//..... really helped manage those.....took them [hot flushes] down to a very, very low level. /

Another leader had her own unique approach to managing her night sweats. When asked by her GP if she needed any medication:

/ I said 'no I can control my temperature by waving my foot around in the air and that's fine', and so there was never any discussion of any medication. I never asked for any...../

In contrast to those who preferred non-pharmacological approaches to alleviate symptoms, one leader expressed her concerns about *alternative* approaches.

/.....all of the alternative approaches are basically chemicals, anyway. They are just badged differently, 'Oh it's natural!' 'Oh yeah, whoopee-do'. Well, heroin is natural, too; it comes out of a poppy plant. //..... I'm not into that space of finding alternatives delivered by people who are often not qualified and haven't got a clue.....I'm not interested in putting something into the system that I don't understand and don't know. It is my science background. /

A number of participants discussed the circumstances under which they may choose to use HRT.

For one leader, using HRT would be an option if her symptoms caused her discomfort or began to impact on her capacity to achieve what she wanted.

/.....if it was causing me something like headaches or, something that was quite, a discomfort during the day or started impacting on what I wanted to achieve, yeah, I'd probably be lining up and giving it a go and seeing what happened...../

For another, mood swings and a potential loss of credibility would be the catalyst for using HRT.

/ I think it would be if I got some of the mood swings and I became someone I'm not. // I don't see any evidence that I'm suffering any mood swings and therefore I maintain my credibility with the people around me and that is all that I'm worried about, but if I was going through deep depression or things that were changing the way I might be perceived, then I would consider that [HRT] then. // I think it would be if I got some of the mood swings and I became someone I'm not. /

Although she did not envisage using HRT herself, one leader expressed her belief that she did not expect others to be *martyrs* and not use HRT if they felt they needed it.

/..... if you need that sort of thing that's fine, that's what you should do. I don't expect people to be martyrs and you know, 'Thou shalt not take HRT'. /

In contrast, one leader expressed strong concerns about what she considered was the inappropriate promotion of HRT use.

/ Women [in the past] were being encouraged to use post-menopausal hormones whether they needed them or not. /

Although she said she had concerned about choosing appropriate treatment options, one leader did not feel that she had access to current information about the pros and cons of HRT use.

/..... maybe my information is out of date and maybe I haven't sorted it out so much, but from time to time I think about 'Oh HRT, right, I had better see what the latest bit of information is and what we should and shouldn't do' and probably that information is somewhere, but I never really feel that there is a place that I can get the latest 'what's happening today?' and the pros and cons. /

Deciding between the risks and benefits would reportedly be factors in determining appropriate treatment options for one leader.

/I mean it is like everything else you do in life. You have to look at whether you go for short term gains or you think long term. I suppose in many ways it depends on what kind of a person you are and what kind of a risk taker you are. I think I've always been a bit of a risk taker and I would be going for the immediate warning. if it was something that was definitely proved to be cancer causing or something, then obviously you would look for an alternative. But, I think that if you are not managing, if you are not coping, and that seems to be the better option...../

Several leaders had used or were currently using HRT to manage symptoms. A number used HRT for short periods either because of unwanted side-effects; because they did not find it effective or because they decided they could manage without it.

One leader was prescribed HRT to help manage heavy periods but found she had an adverse reaction. She decided to *soldier on* without it.

/..... the doctors then put me onto hormone replacement therapy, but that didn't agree with me and I went off it very quickly, because I used to get very sore breasts and that sort of thing. So I just took myself off it. I thought, 'No, I'll just soldier on.' I really just thought, 'I've got to carry on through this because I'm not going to take hormone replacement therapy. It doesn't suit me.' I didn't bother looking at alternatives or anything else. // I think I probably just took myself off it [HRT] and thought, 'I'll just get on with it.' /

Another participant was persuaded to use a very low dose HRT to manage symptoms after finding alternative treatments ineffective.

/.....very low dose, the HRT, but I felt that was stopping me. I didn't like doing it. I'd tried all the herbal things and everything but I didn't want to take in HRT but I was not able to function really, I was so tired and that made it difficult at work and you've got to put on a bit of a face you know, at work. You have to, you have to be seen as functioning and you're being paid to function and all of those sort of sorts of things and I went through a period there where I just couldn't function.// It's not something I..... I didn't stay on for a long time. I went off it again and then I went on it again at another period, the lowest dose you could have, for about another 6 months...../

Although HRT provided benefits in the short term, one participant said she did not necessarily believe she would use it indefinitely.

/ The quality of life, the quality of job, able to manage, and understanding that it may not be something that you are going to do forever.// I was reluctant to [go off HRT] while I was still at a busy job, but as soon as there was the opportunity I thought, 'I don't need to be having these. I can manage without them.' I know a number of my friends did that at the same time. We used to talk about the second menopause wave that some of them were getting. /

The experience of symptoms after ceasing HRT was also discussed by another leader.

/ I know I went off cold turkey..... I went cold turkey and then everything came back with a vengeance.// Even though I had stopped menstruating, you know, I was through menopause, but everything came back with a vengeance. /

When asked why she came off it:

/ Well, because I thought, 'Well, I'm through menopause, I don't need it.' I really hadn't researched how you go off it, so I went back on it and then it might have been a couple of years later I weaned myself off. /

Another leader who eventually ceased HT discussed having a recurrence of the night sweats.

/ I did start with night sweats again, but I....// I got through it. I would have had more minor symptoms at that stage. // I can't even recall whether there was any of that low feeling. If there was, it wasn't important then. /

One talked about the influence of her peer group on her attitude to HRT.

/..... all of us, I mean, there are sort of like 8 or 10 of us in that group, and I can't remember anybody being anti-HRT. /

I'm dead or I'm on HRT.

A number of participants chose to use HRT to address their symptoms. For some, this decision was taken despite the risks they (or others) believed may be associated with its use because of the perceived benefit of the treatment.

/ I can remember people saying to me, 'Oh it's terrible being on HRT. You shouldn't be on HRT, it is so dangerous' and blah-blah-blah. I said, 'Do you know what? I took a choice. I'm dead or I'm on HRT.' I didn't want to die. That's how extreme I felt it was. I really could not have continued living that way because I mean it was horrible. /

/ Well, you have got to map the risks and rewards of all these things, as they say, as even my HRT doctor says. /

Two leaders described how they had been inspired to use HRT after hearing a prominent Perth gynecologist and author speak publicly about managing menopausal symptoms.

/ I was feeling very unloved and overburdened, unnecessarily I thought until I met Dr Margaret Smith and she just turned my life around by putting me on

HRT// I really never ever had focused or had heard a lot about what could be real symptoms of menopause and wasn't even recognising that that might have been the case. / I heard Margaret Smith on the radio. //..... she was directing her comments to busy women and saying 'you can change your life. You can learn to cope. You just need to take charge of it yourself and do a few things like go to your doctor'. // I probably went to my GP and said 'I've got to see this woman'. I then went and heard her speak to a group of women at a fundraising luncheon and I said to her 'How do I get to see you, and how soon can I see you?' So I never looked back and apart from the medication she put me on I've got to say her personally she personally was a great influence on positive reinforcement...../

The second leader described a similar experience.

*/ I went to a lecture quite early on in the piece that Margaret Smith gave. /
/.....and that influenced me in terms of, 'You don't have to put up with these symptoms; there is something you can do about it.' So I did look into HRT really quite early in the piece.// I can remember it so it was quite meaningful at the time.....// I think it was more meaningful coming from a woman than some of the, male gurus./ I suppose I trusted Margaret Smith.// She made a lot of sense to me. /*

After some initial difficulty getting information and advice from doctors about HRT, one leader reported that once the treatment was established, *everything was perfect*.

*/ I think it was about a year and a bit before I actually even got the first HRT, but that then took another six months for me to find the right place.//
Everything was perfect; I mean, just everything. I was normal. That was the thing. I was normal. I felt completely normal. I could deal with the things that I wasn't able to deal with. /*

She goes on to talk about how she believed her behaviour changed after starting HRT.

/certainly at board level, a complete evidence of change. I implemented so many things. All of those areas that I was trying to do things and then somebody would say 'no' and I would cry, I managed to change that whole really culture and way of dealing with everything from recruitment through to firing and everything in between. /

Hot flushes and a waning libido were eventually the catalyst for one leader to use HRT.

/ the two overriding symptoms that have really troubled me are hot flushes and loss of libido.// The hot flushes were getting absolutely beyond a joke. I remember, what finally pushed me over the edge. I was at dinner and sweat was dripping down my chopsticks at a Chinese restaurant, and everyone was looking at me laughing.//. I thought, 'This is ridiculous. This has gone beyond a joke.' So I went and did something about it. So it got that bad before I was driven to do HRT. // I mean, what I really wanted to cure was the hot flushes and it [HRT] did. . //It was the hot flushes, yes, that was the real trigger. I let it go on too far. I mean, perhaps awareness is a really interesting point. /

Another leader was not sure whether the benefits she experienced in using HRT were due to physical or psychological factors.

/..... I did, [find HRT effective] and whether it was a psychological thing or whether it was physical, I'm not sure. My belief is that it was physical in that it just gave me that, you know, more level sort of stabilising. /

Leaders who were able to use HRT for extended periods of time reported very positive outcomes.

/ She [the GP] treated the symptoms. She said, 'Let's try this' and 'we'll try out this dose', and that was what I stuck with. It was all fine, and I went back to see her probably a few months later and I was able to report a transformation. // I think I was sleeping better. I certainly didn't have the sweats, but I suppose the most powerful change was this kind of lifting of the mood. I just kind of felt that

it was almost palpable. It was amazing..... // It was absolutely amazing. // I would have felt that I would have coped better [on HRT]. I certainly wouldn't have been battling. I was more sort of energetic. I mean, a lot of my work wasn't at work. I had to do a lot of things after hours.// So, if you are feeling a bit low and you are going and meeting new people and you are trying to kind of be the face of an organisation, it becomes a bit of a struggle. So my sense is that all of that changed and I went into that with a lot more energy. /

A successful career and better relationship with her husband were attributed to the benefits of HRT according to one participant.

/..... I then went on to have a very successful career and have had enormous energy; able to do it, felt well, felt fit. I would have to say that I have probably worked at the most difficult job and position, hours and that sort of thing. So I just attribute, my ability to cope with a lot of things has been to my use of HRT. My relationship with my husband, everything improved. /

She talked further about her determination to continue using HRT even when family members tried to persuade her that she did not need it.

/.....I've just been on HRT ever since. Even though my older sister said 'you don't need that sort of intervention, we're of good stock, we don't need it'. But I have said to all of them 'the risks may be there, talked about risks in the paper, but I have decided that I'm going to be in charge of my life and I've now been 16 years in (organisation) and very productive energetic sort of contribution to (...) in this State.// I just knew it [HRT] was making a change...../

For a number of leaders, the benefits they associated with using HRT outweighed the possible risks.

/ I have no qualms about using it. I don't care whether I get a risk of heart attack or a risk of increased breast cancer or of the vagina or whatever. // So, what was best for me? I have no qualms about using it; absolutely not. /

/ I don't like taking anything actually, but I mean, horses for courses at times and sometimes, what's the lesser of the evils. I was always. 'I'm never going to take HRT' but..... //..... you'd get one lot of information and then another lot of information and I think common sense tells me if you can not take any kind of artificial chemicals into your body that's got to be better for you than doing it but to me it was like 'I can't function so therefore I will [take HRT]. /

One leader reflected on how she felt she may have managed had she not chosen to use HRT.

/ I think I would just have been worn out, worn out quicker than I was. I think I would have been worn out. /

A number of participants commented on their reactions to the negative publicity regarding the use of HRT, following the release of the Women's Health Initiative (WHI) report in 2002.

/ I was reluctant to go off the HRT and even when that first lot of research came out which questioned whether I should be still on it, I went and saw my GP and had a long chat with her and said, 'Look, I'm reluctant to do anything.' I said, 'Oh yeah.' I think it was a bit like a crutch./ I think when that first lot of research came out I wasn't totally convinced and I kept my thinking that when I retired I would. I think that she was suggesting that I might come off before I actually did, but I said, 'Look, I don't want to risk it. I feel I need to just keep an even keel until I finish off at work and so on.' So I think she was a very well informed and good GP for women. /

/ we [a group of friends] were talking about the going off them [HRT] because we were all at that point and we were all concerned about the research. So there was some talk around about that time. /

Some leaders expressed doubt about the validity of the research.

/ Well, I think it is a tough one. I mean, I would have to be convinced that the research on HRT was as sound as it is supposed to be. I think there are questions about that. /

/ I doubt the validity of that study [WHI study]. I discussed that with my doctor. I didn't read the report. I only read what was available in the newspaper, and I was very skeptical on the way it was reported. // Doctors are a lot more comfortable about prescribing antidepressants.// Well, you know, you have a choice. Obviously you have to be guided in making your choice and to me it was effective. I don't have a medical background to say any more than that. I can only go through myself. /

Another leader said that despite the negative publicity, she always returned to HRT because of its positive affect on her life.

/ Look, on the odd occasion when there's been bad publicity, I might have stopped for 5 or 6 weeks, but I always returned because I thought, 'that is what has turned my life around'...../

Leaders related different experiences regarding the change in attitudes to the use of HRT.

/ there is an anti. None of my friends take HRT. I see one particular friend of mine in England, and she was this fabulous fun sexy great woman, and she is now a sad miserable grumpy, and almost lost her sexuality. /

/.....all of us, I mean, there are sort of like 8 or 10 of us in that group, and I can't remember anybody being anti-HRT. /

Superordinate Theme Three: Keeping Up Appearances

For many leaders, maintaining the appearance of control that they believed was expected of them in a leadership role was paramount. In addition, a number of participants reported holding the perception that they (or women in general) may be unfavourably judged if they allowed others to become aware that they were perimenopausal or experiencing symptoms.

Fronting up and putting on a bit of a face.

A number of leaders talked about their own perceptions about the way they felt they should appear when in the workplace.

/.....you have to front up and you've got to be seen as capable and competent and in control and all of those sorts of things and .you've got to look right too at work. You're expected to look neat and tidy and presentable all the time and I think the days are gone where you had to be power dressing, that's all gone fortunately, but you still, to be dripping wet..... /

*/.....you've got to put on a bit of a face at work. You have to be seen as functioning and you're being paid to function and all of those sort of sorts of things and I went through a period there where I just couldn't function. /
/ I would have been more conscious of being more, seemingly even at work than I might have been personally. /*

One leader reflected on the expectations she believes women place on themselves and are *conditioned* by others, to accept.

/.....there's just a little bit of a fine line. It's a little bit of 'give yourself permission to have this' as well. We can tend to be superwomen when you're in a senior role and you're expected....., women are conditioned to all of that as well. We've got partners and family and all of that sort of stuff and a lot of women have family at home when they're doing this so that would be even

harder I think. /

In addition to the perceived consequences of negative perceptions or judgments on career prospects or credibility, one leader talked about the importance of maintaining the appearance of control so that those reporting to her felt comfortable about seeking her advice and support.

/.....it's more like the impact on them rather than the impact on me. I like to feel as though people feel comfortable about coming to talk to you or feel they can cope if they feel that I can cope. If they feel that I'm not coping I don't think that's good for them and you're there to support other people//.....they need more leadership, they need to look to you as being a stronger role model and all of those sorts of things.// It's about them, it's not about me. It's not about me feeling embarrassed 'cause I don't think I am particularly embarrassed it's about how they would feel about coming to me that would worry me. // I see my role of there to coach them and to support them and to, to get them competent enough and develop them if they think that you're down or you've got issues or you've got something then..... they're good people, they're nice people who have a sense of care about you as well and they'd feel like they were imposing on me.../

Show your weakness and you are lost!

A number of leaders reflected on how they and other women (in general) may be concerned about revealing any indication that their symptoms may affect their performance and the possible ramifications for them in terms of their career prospects.

/..... if you are in a management position, you don't necessarily want people to know intimate things about you because that can be a problem/ I think there is that professionalism there, yeah, of not letting them [colleagues] know. /

/ There might be some subtle pressure I guess to not be seen to let something

like menopause have an impact on your performance at work. /

/..... it could be a problem in terms of promotion, from a generic sense. I can imagine that women would think, 'Oh no, I can't tell them about that because that might influence their decision about whether I can manage this or manage that.....' /

/.....professionally, women are reluctant to publicly acknowledge any weakness in their coping because people, in particular in a male dominated profession, are very quick to say 'oh well it's a woman's thing and you know, they're suffering and they need to be understood and we need to overlook them for the next promotion or whatever'..... So that's why women are, in those very competitive areas, to be seen to be coping and to admit that there are down days is not good for their professional promotions. /

One leader gave a description of how she believed she needed to appear in order to maintain an aura of competence.

/..... it is difficult because you don't want to show anything that you are not as, in your armour. /

Another leader describes how she was warned about the ramifications of revealing any sign of *weakness* in her particular workplace.

/ I got told when I first [joined the organisation] I had [other colleagues] explain to me how you look for one another's weaknesses. That is the way the game is played. / So show no weakness; show your weakness and you are lost. /

One leader described how in her *line of business* others were inclined to look for your weaknesses and talked about her efforts to avoid putting herself at risk if she felt her symptoms may have made her more vulnerable to *an attack*.

/ I've seen, just because of my line of business, where they look for your weaknesses and they go for your weaknesses, so you can't show any weakness.

So if I thought that maybe I wasn't..... If ever I think maybe I'm not 100 per cent, I take great care not to put myself in a situation where it is going to show// And because I was very lucky, it was only for short periods. I could just cut back for those short periods. I could still work. I could do paperwork or whatever, but just not put myself in the situation where you are the centre of; you know, in my line of work, an attack. /

One participant discussed her perception that being open about *physical* things was more acceptable than disclosing problems of an emotional or intellectual nature.

/..... if I had hot flushes, things like the very evident physical things like that, I did have a laugh about it because what else can you do, but the more subtle things like anxiety and loss of memory would have been harder, well, particularly anxiety, to share, I guess.// there was certainly in my mind a distinction between the really physical signs and then the more emotional signs. I felt I had to hide the more emotional.....// Yes, it is okay to break your leg but it is not okay to get a bit fed up. /

She provides further insight into how she believes she needs to behave in order to maintain her credibility with her male colleagues.

/ You know, you want to be..... Well, I had to be the same [as her male colleagues] as I could possibly make myself. I mean, that is how I always felt. You have got to be like them. /

Another leader also talked about her perceived need to present herself in a certain way in order to be *the face of the organisation*.

/..... if you are feeling a bit low and you are going and meeting new people and you, you know, are trying to kind of be, the face of an organisation, it becomes a bit of a struggle.// I think I would have tended to hide any feelings, any irritability or whatever. /

Several leaders made comments about how they believed women generally may be *judged* within the workplace.

One leader suggested that a women was more likely to be judged based on her explicit behaviour rather than because she was perimenopausal.

/ I think that is a perception that people have that 'Oh well, someone will use that against me,' but I've never in my whole life ever heard a conversation that says, 'Oh well, she has got this issue or that issue' and if she is very moody, then it might well be the moody bits that make people uncomfortable.// No, it's not the fact, but it is just how it is manifesting itself, and if people don't understand that, then they only take it on face value that, 'Oh gee, she's a moody bitch and no one likes dealing with her.' Then that's an issue. I mean, I have sat on lots and lots of selection panels of senior women where it is a table full of men and me where we are selecting people for a particular job and I've never heard any remark ever. /

Another leader provided a different perspective, believing that women are judged more harshly than men particularly if they are deemed not to be coping or functioning optimally.

/ I think that for women, and older women, it is a problem because age does matter when women are concerned much more than men in the professional areas, and if there's any indication that we are failing or resorting to assistance or whatever, it is very harshly judged. /

One leader talked about the judgments she believes are made about women's behaviour generally.

/ I think already women are judged by being over-emotional about things anyway, so that if you deal with something in that female.....Well, it's not even that. It's actually probably in that female PMT way when we are a bit irrational..... You know, you have got to fight that in management or in the business world throughout, I think, and be aware of that, even the PMT if you

have strong PMT. Because I had bad PMT anyway in the olden days, so I knew about PMT, but having it all the time is another case. /

One participant believed there would be few concessions made for women at this stage of life just as is the case for working mothers.

/ In this environment there are not that many professional women anyway, and you always very much welcome their participation. So I don't think of women in terms like that [being perimenopausal]. I think the only thing that I could liken it to is being a working mother where there is stigma attached to that and there are expectations and there is not a lot of leniency. So I think it is probably things like that where you have got outside influences that do impact on your working life, but I think particularly from a male perspective there would almost be no thought about that. I can't say for sure, but I think that certainly my board would be, 'Well, we pay you to do a job and we expect you to do it and you work around whatever those issues in your life happen to be.' /

Another leader who had worked in a predominantly male environment had some comments regarding factors she believed affect the way men might respond towards women having hot flushes in professional settings.

/ It is very hard in today's society that a lot of men don't know where to look, don't know what to do, because we have taken away the ability for them to have a little jibe and a little joke because someone will get upset about it, whereas I reckon that if I can put the humour out there to start with, then they all know they can have a little jibe back and we all get on with business. /

Another gave her insights into how she believed men may perceive the plight of perimenopausal women in the workplace.

/ I think probably men have thought, 'Well, women have gone through it for years' you know, 'and they have got on with it. Why can't they do that now?' It is just like, 'Get on with it' you know. /

Women and men may react differently in the presence of someone experiencing a hot flush, according to one leader.

/ I think they [women] are probably more uncomfortable than the men that I bring attention to it [hot flush]. That might be the case //..... in a professional sense, I am just trying to think. No, I think they laugh like the men and laugh sort of at/with me, but won't admit it themselves...../

One leader believed that being *menopausal* and exhibiting certain behaviour may jeopardise a woman's chances of promotion. She related her observation of this happening to two women she knew.

/ I have seen sort of pretty dynamic women who get to that stage and that would be their next stage, but somehow they haven't got to that next stage and I believe it is because..... The two women I'm thinking about both have been menopausal and I think that their behaviour may have put doubt in the mind for them to get the next step. Not that they turned it down, but they missed out. You know, something, their behaviour changed or maybe they dealt with something irrationally or whatever and therefore, 'Oh, I don't think we will do that because, you know, Mary, see how she reacted to such and such. You know, she really blew that up. Well, we don't want that on the board or at that level.'/

Superordinate Theme Four: It's Lonely at the Top

Many leaders described the sense of *isolation* they experienced while in leadership roles. This was often associated with their desire to maintain an aura of confidence and capability as reported in the preceding section. In addition, many talked about the lack of peer support and opportunities to socialize and share information due to the time constraints often associated with their high work demands.

No one to talk to.

One leader describes how she manages the sense of isolation she experiences being in a management position. She also points out that peers with whom she may feel more comfortable talking to may not be *thick on the ground*.

/ I think in a management position you are more isolated anyway from staff, so you are looking at people in line with you, or perhaps even above you, as a mentor. They may not be thick on the ground. // So there is that issue and then the separate issue, of course, is whether you have got people that you connect with and that you want to share things with. /

Another leader talked about how she believed her time at work restricted her opportunities for talking with friends.

/ I think for me, one of things that has really struck me as being an issue is that we have no one to talk to. It is very isolating being a woman if you are in a management position because you predominantly spend most of your hours at work. /..... so it doesn't really leave any room at all for chatting. I'm not really a chatty person, I suppose, because I have always had a job like this where it has been very focused, and so on. I'm not a coffee person, so I think it is a real issue for someone like myself because you are quite isolated and you don't get to talk about things that other women are experiencing..... So we really don't communicate. We don't have a forum to communicate when you are working. / I have a group of women my age..... There are six of us..... //. The only time that I really do that [talk about personal issues] is when I do get with these girlfriends of mine a couple of times a year. /

Having no peers she could relate to was also an issue for another leader

/ I had no peers I could relate to and all that sort of thing. /

Another also reported an absence of women peers in her workplace. She made the point that, in her experience, women are in the minority in senior positions.

/..... in senior positions, you know. Most of the people I deal with are men. /

Talking to those on a *peer level* would be preferable to talking to a *report* according to another leader. She also describes how she might be more inclined to talk with friends about the extent to which symptoms were impacting upon her capacity to manage effectively at work.

/ I think it is when you're in the leadership role, if you've got a collegial group, on like a peer level, where you're more likely to talk, I mean I'm not that hierarchical really, but it does tend to work a bit like that. I think it's that I wouldn't be comfortable talking with somebody who reported to me about not feeling like I could cope. I wouldn't talk to them about that. I'd talk to my friends about 'this is really impacting on my work. I'm so frigging tired I can't get out of bed. I'm feeling like I can't manage properly at work. I feel like I'm not doing it'. I wouldn't do that to a 'report'...../

A no-go zone!

A number of leaders talked about the taboo some believed was associated with talking about personal issues like perimenopause with colleagues. One described this as a *no-go zone* even with other professional women.

/ Professional women tend to be quite good support for each other I think, but I still think that that [discussing perimenopausal symptoms] is a no-go zone.// there is lots of support about being a working woman, how hopeless your husbands are; how much teenage children give you the shits; how you don't get paid fairly. I mean, I think the issues that would be covered in 'The West Australian', they are the ones that would be talked about, but certainly I can't think of a professional woman I've had a discussion with about menopause.// It just seems a totally taboo subject. /

The distinction between discussing *work stuff* and *personal stuff* is also highlighted by

another leader.

/..... if you talk about work stuff, that's easy, but talking about personal stuff is very difficult unless you are really close. /

One leader reported that the subject of perimenopause had not been discussed at any seminar she had attended.

/..... never talk about anything like that at any of the seminars and things that I have been to. The only time people might talk about it is if they went to, say, something with Margaret Smith which is about menopause or something. /

One leader suggested that there might be a greater degree of tolerance in regard to women experiencing mood changes, if people were to talk about perimenopause.

/ The trouble is that because people won't talk about it, then people aren't tolerant, because they just think 'she's having a snooty mood' or 'she is in a bad mood today.' And because there is no way of anyone actually saying, 'Well, yeah, just give me a bit of space in the next two days', they won't even ask other women to give them a bit of space. Instead they just get ratty and I've always found that hard because then you don't know how to react. /

Two leaders talked about the barriers to offering advice about *personal stuff* in the workplace.

One who had found HRT helpful was reluctant to *push* her views about it on women colleagues.

/..... there's a lot of negative publicity about it [HRT] and they weren't sure that that was for them and it's not something you want to push on women colleagues...../

She reflected on what she would like to say to colleagues about her experience of using HRT to manage perimenopausal symptoms.

/.....still now if I pick up a colleague, or one of my peers, they may not be driving, they have very quiet lives compared to mine. There's an enormous difference and I would just like to say to them, ' you've missed out - you've missed, you're missing life! There's so much life to be lived.' /

She goes on to say how she would approach a colleague she thought may be experiencing perimenopausal symptoms:

/ I'd be very sympathetic and I would very gently. Pose the situation or the proposition that maybe they ought to consider HRT. /

The other also talked about the need to be cautious about offering advice on personal issues.

/ If I knew her better I would say, 'You probably would benefit from.....' but people have to be receptive to that. You have got to be so careful, don't you? Especially if you talk about work stuff, that's easy, but talking about personal stuff is very difficult unless you are really close. //..... people are becoming much more, I think, open to discussion, but it is really a tricky one, isn't it? /

Recommendations for Other Women in Similar Circumstances

At the end of the interview, leaders who had not done so during the course of the interview were asked for their opinions in response to Research Question Four: *What are the recommendations for educating and supporting women in similar circumstances?* Although a number of participants provided general comments about the issues confronting women in leadership roles, only a few were able to offer specific advice or recommendations about interventions or strategies that may assist other leaders who may be experiencing perimenopausal symptoms.

One leader talked about the value of mentoring and advocacy for women generally.

/ It is really hard to generalise, but there are a lot of women's support groups now where a lot of women are realising how nice it is to be a mentor or an advocate, particularly advocacy. I don't like the term 'mentoring' much, but the greatest value older women can do is to actually offer an opinion that a younger woman will be suitable for a job, and be an advocate for her. The organisations that are getting a lot of women coming through the system are those where they have got advocates and that is because they have been open enough that people have learnt to trust them, and I think that is part of the thing we have to deal with. // I'm seeing it a lot now as I get rung up a lot for suggestions on who might be a good woman to have on a board. So I can be an advocate for some of the women who have not yet broken out of the not-for-profits. It is important that we do that and it is really important that the women that are in the system now offer those names forward. /

A number of participants indicated that they believed women need information in order to make informed decisions.

/ I think for other women, they need the information in order to make the judgment. // And perhaps they need some good stories from women. /

/ I just think that there is a need for women to be guided through it in a more general..... the education on it, the general education on it, but also how to deal with it in the workforce has not been addressed. It is sort of, not a taboo subject, but 'Well, so what? Just get on with it' and I guess that is sort of the attitude I have taken too, because it is how I sort of deal with it myself..... /

/..... what I'd recommend to other people is, try to develop some awareness and really to be able to take enough time to at least look at what's actually happening here and 'why am I like that?' I didn't really connect the two things...../

The absence of *advocates* in the community who could give a positive lead to women in regard to the benefits of using HRT made another woman *sad*.

/..... it's sad that there are not more advocates out there in the community who can give a positive lead to women and say ' give it [HRT] a go because it's turned my life around and maybe, you know, there are opportunities for you to turn your life around instead of resorting to saying ' I'm depressed, my husband's being horrible to me or, he doesn't see it, my point of view', and turning to antidepressants which we know are not a good thing to, not a good option to be pursuing. /

A more informed medical profession was needed according to one participant.

/ I think the medical profession actually is probably what needs.....the general medical profession are those who need to be more informed in order to inform us accurately. /

Other Issues Raised and Comments Made by Participants

A number of comments were made that did not relate directly to the research questions. A number of the following comments have been reported earlier in relation to themes associated with the research questions. It is considered appropriate to include these in the following section with reference to the broader issues they encompass.

One leader described how she believes she may once have reacted to other women who may have been experiencing perimenopausal symptoms in the workplace. She believed she may previously have lacked insight into the possible problems faced by such women.

/ If I find them difficult to deal with, I might try and find a few ways around it, and that maybe where I could come up against a woman who is menopausal and not really quite understanding her issues. /

Another leader described how she believed that women's self-perceptions generally differ from those of men.

/.....a lot of women aren't self-confident about their own abilities, whereas men will brave their way through. If they can spell the title, they will think they are 90 per cent towards getting the job and that will be their only qualification they have got is they can spell it or think they can spell it, whereas the women will want to be sure that they absolutely 100 per cent understand it, or they are full of self-doubt. And I've never understood that, never understood it. /

A number of leaders talked about situations in which they had observed the experiences of other *menopausal* women.

/..... a friend who does not work and has not worked for years and years and years was saying, 'Oh, I'm always tired and this is happening and I'm feeling bloated and I'm putting on weight' and so forth. I felt that because her life is very different and she doesn't have the same sort of stresses imposed on her life or the commitments to a sort of working life, maybe she doesn't cope with it as well because there are no sort of extra-curricular things in her life as a distraction...../

Broader issues associated with the cultural aspects of ageing and the denial of the legitimacy of perimenopause as a *transit through life* was also raised by one participant.

/ There is the other thing, too, about menopause. It was something I remember thinking about, and that is the whole cultural thing about ageing and perceived loss of sexuality and all of those sorts of things.//..... and I think a bit of denial about it actually happening as opposed to, I suppose embracing it as part of women's transit through life that, 'This is what happens'. And much the same thing for men, too, when they get to that age and whatever happens, they grasp that they are not going to get higher up the thing or whatever, and they have similar sorts of issues. Yeah, if we didn't have this single minded focus on achievement and how you have got to perform, you know, and the idiocy of things like having to be there at a breakfast at 7.00 in the morning and work through to half past seven at night. /

When asked how she thought a woman's personal experience of the menopausal transition might affect the way she managed other perimenopausal women in the workplace one leader expressed her doubts about making generalizations.

/ My answer would be, 'Depends on the woman' and I think there would be women who have very severe symptoms who would not be sympathetic to anyone else//.....and there would be women who basically breeze through it with virtually no problems, who would be highly empathetic and so I'm not convinced that experiencing it makes you better or worse at helping other women.....//.....it's much more about your own values.....// I'd need to be convinced that having the experience makes you empathetic...../

She went on to provide some insights into the ways in which she believed women support each other in the workplace.

/ I think there's a whole lot of gender stuff in there around how women support each other in the workplace because you can have highly feminised workplaces that are really vicious to each other, so I've said this place [her workplace] is women friendly and the women support each other but you can have the same number of women here and you wouldn't want to lean forward because that'd give the opportunity for them to put the knife in your back...../

One leader reflected on the manner in which she hoped she would offer support to others in her workplace if she believed it was required.

/ What I would hope is that my relationship with others be open enough that people can come and tell me what's going on; that if I noticed it I'd have no problem in asking 'are you Ok? Is there anything that you need? Have you thought about.....?/

Summary

The findings presented above represent a discrete account of the participants' narrative, with the researcher's comments limited to paraphrasing, comparing and contrasting the participants' remarks. The development of superordinate themes completes the interpretative process of data analysis.

The following chapter will discuss the findings of the study and how they relate to the extant literature. The issues raised that may subsequently inform further research and provide the basis for educational and support strategies for other women in similar circumstance will also be presented.

Chapter Five: Discussion

Introduction

Discussion of the findings will follow the format established in the previous chapter. A brief discussion of the participants' comments regarding the symptoms checklist will be followed by a discussion of the Superordinate Themes which relate to Research Questions One, Two and Three. The chapter will conclude with discussion of issues raised in response to Research Question Four and other issues raised by the participants that were not directly related to the research questions but of significance to this study.

In accordance with the established protocol, italic script will be used to denote the words and phrases used by the participants and as originally cited in the previous chapter.

In addition to discussion regarding individual symptoms, a number of participants made general comments related to the checklist and definitions supplied prior to the interview. These comments reflect aspects of the leader's understanding and awareness of the nature and onset of perimenopause and are therefore considered important in providing a deeper understanding of the broader issues that may affect female leaders at this time of their lives. These comments will now be discussed.

Participants' Comments Regarding the Symptoms Checklist

Existing evidence reveals that women are often ill-informed about both the nature and onset of perimenopausal symptoms (Lyndaker & Hulton, 2004; Twiss et al., 2007). It was therefore expected that female leaders approached to take part in the study may have disparate levels of understanding about aspects of perimenopause. In consideration of this, all prospective participants received the symptoms checklist and definitions of the terms perimenopause and menopause prior to the interview. This information provided a basis on which women could determine their own eligibility for the study and was also intended to act as a catalyst for discussion. The checklist

was not intended to be definitive, but rather as a guide to indicate the possibility of a hormonal basis for a perceived change in the nature or type of symptoms experienced.

Although all participants checked at least one symptom, some were unsure about whether certain symptoms were in fact associated with perimenopause. This uncertainty was consistent with the findings of Twiss et al. (2007) that women are less inclined to recognise perimenopausal symptoms such as joint pains that are not usually associated with the menstrual cycle or menstruation.

The majority of participants however, reported finding the checklist useful as a catalyst for discussion and for some, as a prompt, reminding them about symptoms they had experienced in the past and often not associated with perimenopause. In addition, consistent with the findings of Lyndaker and Hulton (2004) and Twiss et al. (2007), a number of participants indicated that they were not familiar with the term perimenopause and did not know that perimenopause could precede menopause by several years or that symptoms were often at their worst at this time.

Several participants expressed regret that they had not recognised at the time, that symptoms they were experiencing may have been the result of hormonal fluctuations. A number indicated that better knowledge and awareness may have enabled them to make more informed decisions about treatment options. One participant said she wondered if her decision to retire from a job she had previously enjoyed had not been influenced by symptoms she later recognised as having been associated with perimenopause. Other leaders reflected on the distress or disruption they had experienced as a result of uncharacteristic or aberrant behaviour that they had not recognised as possibly being associated with perimenopause. This was consistent with the findings of Boughton and Halliday's (2008) that uncertainty about the nature and origin of symptoms caused women to experience distress and placed many at a disadvantage in regard to seeking appropriate advice and support. Boughton and Halliday also reported that many of the women in their study who experienced symptoms that they did not recognise as being associated with perimenopause believed they were losing their sanity or experiencing psychiatric problems.

A number of participants, who did seek medical advice for symptoms they initially suspected may have been hormonally based, were reportedly sent for blood tests ostensibly to ascertain menopausal status. This is a concern because it is outside the recommendations of the AMS (2010 d) which advises doctors not refer women for blood tests for this purpose because the results may be unreliable. They recommend that doctors make their diagnosis based on clinical signs and symptoms such as those on the symptoms checklist. In addition, telling a woman she is not *menopausal* is misleading if the doctor does not also explain that although the woman may not have reached actual menopause, she is likely to be in the menopausal transition and experiencing perimenopausal symptoms. Failing to clearly explain this may leave the woman more distressed and confused about other possible causes of her symptoms. For example, Prior (2006) found that misdiagnosis often led women to erroneously believe they were suffering from conditions such as fibromyalgia or chronic fatigue.

Changing attitudes towards the use of HRT may be another obstacle to women's receiving timely advice and treatment for symptoms. Research indicates that since the release of the WHI findings in 2002, doctors are less likely to raise the issue of perimenopause with women. Twiss et al. (2007) reported that doctors are now more inclined to wait until women's symptoms become more distressing or until they raise the issue themselves. In addition, Simon and Reape (2009) report that health care professionals may lack an understanding of the pertinent issues and overestimate the risks associated with the use of HRT.

It is also possible that health care professionals recognise that women associate being menopausal with getting old and may react with some indignation to a suggestion that symptoms they may be experiencing may be associated with the menopausal transition. Research suggests that in Western societies, menopause is associated with negative beliefs and images (Hunter, 2003). Marvan et al. (2008) cite studies that suggest that women associate a loss of status and physical attractiveness with menopause. Anecdotally, women often do not contemplate menopause until they are nearing their fiftieth birthday and in this regard, may associate this life stage with becoming old. Educating women to understand that the hormonal changes associated with perimenopause may precede actual menopause by several years and may even be experienced by relatively young women in their late thirties or early forties, may help

to reduce this stigma. Lyndaker and Hulton (2004), recommend that women should be educated about perimenopause during their 30s so that they are able to recognise symptoms and seek appropriate and timely advice.

Summary

Providing participants with the symptoms checklist and definitions of the terms perimenopause and menopause provided a basis for discussion of issues associated with the recognition and attribution of symptoms. Although no attempt was made within the current study to ascertain the participant's prior understanding of the terminology or nature and onset of symptoms, it was evident that a number of participants had been unaware of the term perimenopause; the age at which symptoms may first manifest or the range of symptoms that may be associated with fluctuating hormone levels. It is a concern that even amongst a group of intelligent and well educated women, there is still some apparent lack of clarity about these issues.

Discussion of individual symptoms identified on the checklist provided insights into the broader psychosocial issues associated with the leaders' experience of perimenopause. The commonalities and differences within the reported experiences provide the basis for the development of the four Superordinate Themes which will now be discussed.

Superordinate Themes

The four emergent superordinate themes are as follows:

- Distraction, disruption, discomfort and distress
- Soldiering on or taking control
- Keeping up appearances
- It's lonely at the top

Each of these superordinate themes will now be presented.

Superordinate Theme One: Distraction, Disruption, Discomfort and Distress

As discussed above, all leaders checked at least one symptom on the checklist and all reported some degree of distraction, disruption, discomfort or distress associated with the experience. Although the degree to which particular symptoms affected their lives varied, the commonality of the experience amongst participants was considered to constitute the first of the emergent Superordinate Themes: Distraction, disruption, discomfort and distress, which is comprised of the following second-order themes:

- Disturbed and interrupted sleep
- Hot, sweaty and red in the face
- I mourn the loss of my libido
- Don't wear white!
- Irritable, anxious and feeling low
- A bit more forgetful and less on the ball
- Erratic, loony and emotionally driven extreme behaviour

Each of these second-order themes and their implications for women in leadership roles will now be discussed.

Disturbed and interrupted sleep.

The most frequently checked symptom on the checklist was *sleeplessness*. Of particular interest in regard to this finding was the confidence with which many of the leaders attributed the change in their sleep patterns to perimenopause and the emphasis many placed on this in their discussion. This was not surprising considering that sleep disturbances are reportedly twice as likely during perimenopause (Baber, 2009). In addition, Simon and Reape (2009) reported that insomnia may affect the majority of women during perimenopause and was considered by their study

participants to be the most problematic symptom, often compromising their ability to do their jobs effectively. Other studies also found that disrupted sleep reportedly affected daytime functioning, decreased quality of life and concerns about not getting a good night's sleep often increased anxiety in perimenopausal women (Arigo et al., 2007; Polo-Kantola et al., 2001; Simon & Reape, 2009). Furthermore, the literature refers to a range of health problems that can be exacerbated by or attributed to a reduction in sleep quality including problems with cognition and depression (Godfrey et al., 2009; Motivala et al., 2009; Hudson, 2004).

It was not surprising therefore, that the impact of having disrupted sleep reportedly took its toll on a number of leaders. Several reported that coping with sleep disruptions caused irritability and mood swings as well as increased levels of anxiety and tiredness during their working day. One leader described her tiredness as *debilitating* and reported that she was unable to function at this time. She subsequently resorted to HRT because she believed her lack of sleep was affecting her work performance.

Of particular concern for women contending with the demands associated with leadership, is the possibility that the problems they experience with disrupted sleep may continue for a number of years. According to Crandall (2008), up to 10% of women may experience disrupted sleep patterns associated with perimenopausal and menopausal changes for up to 12 years. It was not surprising therefore, that some participants reported having had disrupted sleep for a number of years.

It is conceivable that having disrupted sleep for extended periods of time, may adversely affect leaders' health, well-being and potentially, job performance. Simon and Reape (2009) reported that some of their study participants lost up to three hours sleep per night. This must constitute a substantial burden for leaders who may already have to contend with the disadvantages frequently associated with working in environments that continue to place extremely high demands on women and frequently offer less support for them than for their male colleagues.

Hot, sweaty and red in the face.

Vasomotor symptoms such as night sweats and hot flushes are the most frequently reported perimenopausal symptom affecting between 70% and 85% of women (Rymer & Morris, 2000; Baldo et al., 2003). It is not surprising therefore, that the majority of leaders checked one or both of these symptoms.

While night sweats frequently affected sleep quality, hot flushes reportedly caused a range of problems for those whose work involved high profile face to face or public interactions. Participants talked about the discomfort, distraction and embarrassment they experienced as a result of the flushing and/or increased perspiration. A number reported that they felt *dirty* or *sweaty* as a result of their hot flushes. For others, experiencing a hot flush in a public situation, meeting or while giving a presentation was more or less problematic depending on whether they believed others would notice and who was present at the time.

Leaders talked about the strategies they employed to minimize the impact of flushing and sweating. Some managed this by paying particular attention to the clothing they wore including *layered dressing* and found that this was sufficient to ameliorate the effects of the fluctuations in body temperature. The need to consider what clothing to wear and how to manage the work environment in order to feel comfortable was a significant issue for a number of leaders and represented yet another distraction within their busy lives.

The extent to which having a hot flush in public caused embarrassment varied depending on the situation. A number of leaders reported that although they were not particularly embarrassed by their flushing, the presence of men or subordinate staff caused them to be less open about the experience. One leader said she would be reluctant to reveal that she was having a hot flush if she believed others might *use it against* her. Others reported that they used humour to alleviate any potential embarrassment in the event of a hot flush, regardless of the gender or status of those present. Similarly, in one of the few studies in this area, Reynolds (1999) describes how her participants used humour to defuse potentially embarrassing situations associated with experiencing a hot flush. Interestingly, one leader said she thought

that in a meeting with men and women, the other women may be more uncomfortable than the men in the event of her *making a joke* about having a hot flush.

In contrast, although a number of participants discussed how their response to the experience of a hot flush may vary depending on the gender of those present, two of the leaders who worked predominantly with men were not uncomfortable about acknowledging or even drawing attention to themselves when experiencing a hot flush. One did however say that she made a distinction between the physical signs (like hot flushes) and what she described as the more emotional signs or perimenopause saying she felt she had to hide the later.

It appears that for a number of leaders, being recognised as perimenopausal was of less concern than the prospect of having significant others judge them as being less capable or more *emotional*. In this regard, a number of leaders indicated that they were more concerned that the distraction associated with experiencing a hot flush may cause them to appear embarrassed or nervous (which they claimed they were not) or in some way lead to significant others misinterpreting their body language. This also reflects Reynolds's (1999) finding that the women in her study were concerned about losing their *poise* in the event of having a hot flush at a meeting or in the presence of a socially powerful group.

Of particular relevance for women in leadership roles is the reported relationship between hot flushes and stress. Research indicates that stress may exacerbate hot flushes both in terms of the number experienced and their intensity (Cutson & Meuleman, 2000). It is possible therefore, that for leaders whose work is demanding, more frequent or more intense hot flushes may be both the cause and effect of increased levels of stress.

In summary, for female leaders who are endeavouring to present an image of poise and competence, the discomfort, sweating and reddening of the skin that often accompanies a hot flush has the capacity to be a distraction that may well undermine confidence and compromise performance.

I mourn the loss of my libido.

Loss of libido and sexual function, and associated urogenital changes are frequently experienced by women during perimenopause (Wren, 2009; MacLennan, 2009).

Although often not directly impacting work performance, symptoms that compromise female leader's intimate relationships may conceivably have an adverse effect on their quality of life and sense of well-being and this may subsequently affect their professional lives as leaders.

Less sexual feelings was the fourth most frequently noted symptom on the checklist, however little discussion was initiated by the participants in regard to this and other associated issues. Urogenital symptoms such as *vaginal dryness*, *uncomfortable intercourse*, *loss of bladder control*, and *urinary frequency* were also often noted on the checklist but rarely raised by the participants as an issue for discussion. A few participants indicated that they believed that certain urogenital symptoms and loss of libido were an inevitable consequence of ageing.

Although one leader said she mourned the loss of her libido during perimenopause, it is possible that other participants felt such issues, although having an impact on their personal lives, did not directly affect their professional roles and therefore were not pertinent to the study topic. McBride et al. (2010) asserted that women often do not report certain urogenital symptoms either because they consider them unimportant or because they feel embarrassed. Whilst it is possible that a number of leaders did feel uncomfortable about discussing these issues in any detail, some did mention that vaginal dryness was an issue. One leader said she would have no concerns about raising this issue with her doctor if the symptom became more problematic while others indicated that they may be reluctant to talk about the issue with a male GP. Several leaders reported that they were able to manage this symptom by using non-prescription products from the pharmacy.

In addition to their own embarrassment about discussing certain issues with their doctor, Kingsberg (2009) found that women were often also embarrassed on behalf of their doctor. She suggested that this concern may have been warranted as health professionals often admitted to being embarrassed at the prospect of discussing such

matters with their patients and clients. It was not surprising that Kingsberg recommended improvements in patient-physician communication and better education of both the women concerned and the health professionals responsible for providing them with advice and support.

It is unfortunate that many of the urogenital symptoms experienced during perimenopause have the capacity to be more than just an uncomfortable nuisance. Women experiencing urogenital symptoms are often at a greater risk of developing problems with incontinence as well as fungal and bacterial infections (Doyle, 2006). These problems may constitute yet another burden for women trying to cope with highly demanding leadership roles. In addition, unlike many perimenopausal symptoms, urogenital symptoms may persist and even increase after menopause condemning many women to ongoing problems that may impact both their physical and psychosexual health (Doyle, 2006).

It is of concern that although these symptoms can often be addressed safely and effectively with low dose vaginal oestrogen preparations (Doyle, 2006), few of the participants (when asked) said that they had been offered this treatment by their GP. It would appear that if confident, educated women are ill-informed or reluctant to raise their concerns about urogenital problems, it could be even less likely that women generally would feel comfortable discussing these kinds of issues.

In summary, health professionals are best placed to provide timely information and advice about urogenital health, libido and sexual function with women whom they consider may be perimenopausal. It would seem therefore that it may be particularly important for health professionals to take a proactive role in this regard as recommended by Kingsberg (2009) and MacBride (2010), rather than waiting for the woman to raise the issue herself. It is also important that women are informed about the broader ramifications for health and general wellbeing of urogenital problems during perimenopause and into post menopause. For women at mid-life who are not using HRT, good health care should include the doctor broaching the subject of vaginal health and recommending treatments such as vaginal oestrogen products that are low risk and highly beneficial for maintaining vaginal health (Smith, 2010).

Don't wear white!

Another issue that has the potential to adversely affect women in leadership roles both directly and indirectly, is heavy or irregular menstruation which often occurs during perimenopause. Unlike the period following menopause, which is characterised by a lack of menstruation, the period of perimenopause is frequently a time when a woman's periods may become heavier and less regular. A number of leaders talked about having erratic or unusually heavy periods which they believed had the capacity to undermine their sense of wellbeing and confidence. One leader talked about feeling she needed to take precautions much of the time just in case her period started unexpectedly. Others talked about not wearing white skirts or trousers at this time and being concerned about meetings or lectures that went on for more than a few hours.

For leaders with busy and demanding work schedules, concerns about the consequences of unexpected or heavy periods may be yet another distraction that has the potential to undermine confidence and wellbeing. Furthermore, as well as the emotional impact of heavy or unpredictable periods, women experiencing heavy periods are at risk of becoming anaemic and this has been shown to affect aspects of both physical and cognitive performance (Garside et al., 2008 ; Szromba, 2009).

Irritable, anxious and feeling low.

As discussed, many of the symptoms of perimenopause have the capacity, both directly and indirectly, to compromise a woman's physical and mental health. Maintaining emotional health and stability are critical in roles that require high levels of decision making and leadership. For a number of participants, perimenopause reportedly heralded changes in (otherwise stable) emotional and psychosocial behaviour. Symptoms identified by participants included *depression, unloved feelings, anxiety, irritability, mood swings, problems with concentration and poor memory*.

Changes in mood were frequently reported and a number of leaders talked about their efforts to manage mood swings and irritability. Some talked about *taking it out* on their families while endeavouring to maintain an aura of coping at work. A number of leaders also reported feeling more anxious at this time although none were confident that this was related to hormonal changes. Feeling *low* however, was more frequently attributed to perimenopause, with one leader describing this feeling as resembling *permanent PMT* (pre-menstrual tension).

The confidence a number of leaders expressed in the relationship between their low mood and hormonal changes gained further support amongst those who were subsequently prescribed HRT. These leaders reported that they were able to detect a change in the way they felt following the use of HRT, with one leader describing this change as a *lifting* of her mood.

These findings are consistent with research which indicates that women are more vulnerable to experiencing anxiety and depression during perimenopause (Soares, 2003). Studies also indicate that HRT, and in particular oestrogen, may improve some aspects of psychological and cognitive function (Morrison & Tweedy, 2000; McIntyre et al., 2005). The capacity of HRT to lift mood in perimenopausal women in addition to ameliorating (or eradicating) other symptoms such as hot flushes is well documented. It is therefore perhaps not surprising that a study by McIntyre et al. (2005), found a statistically significant increase in the prescribing rates of antidepressants following the release of the WHI report in July, 2002. Although further investigation may be required to ascertain a causative relationship, this finding is controversial because this increase in prescriptions for antidepressants coincided with a statistically significant (and similar magnitude) decrease in prescriptions for HRT.

Although only one participant in the current study reported having been prescribed antidepressants, anecdotal evidence suggests that clinicians may now find prescribing antidepressants to perimenopausal women more palatable than prescribing HRT. This is of concern for a number of reasons. Firstly, although certain antidepressant medications such as selective serotonin reuptake inhibitors (SSRIs) have been shown to ameliorate hot flushes (Loprinzi, Stearns & Barton, 2005), they are much less

effective in this regard than HRT (Wolfman, 2005; MacLennan, 2009). Secondly, the use of antidepressants either to treat hot flushes or low mood in perimenopausal women is a concern if women are not being informed that such medications may have side-effects including sexual dysfunction (Baldwin et al., 2008) and an increased risk of bone loss and subsequently, osteoporotic fractures (Saag, 2007; Rosen, 2009).

Furthermore, it is a concern that the reported increased rate of prescription of antidepressants for women as reported by McIntyre et al. (2005) has similarities to the over-prescription of Valium for women in the middle of last century. Discussing this issue and the ramification of the negative publicity regarding the use of HRT, Smith (personal communication, May, 2010) made the following comment:

We have gone back 50 years to the time when women were treated with barbiturates and other heavy sedatives and then Serapax or Valium because hormone therapy was not available or even thought of.

It is possible that there may be psychosocial (as well as physical) implications for women who are prescribed antidepressants for symptoms that may be more effectively and perhaps, more appropriately treated by low-dose, short-term HRT.

This is yet another area where the education of women and their health care professionals is critical if women are to be afforded the opportunity to make informed decisions about treatment options.

A bit more forgetful and less on the ball.

Another controversial issue involves the relationship between hormonal changes and cognitive function. Although there has been much debate about this issue, recent research supports the premise that hormonal fluctuations affect aspects of cognition and memory. In particular, the effects may be at their worst for a short period during

late perimenopause and may involve aspects of cognitive function such as verbal memory (Greendale et al., 2009).

Although one leader attributed her lack of *strategic thinking* to hormonal changes, others who said they were *a bit more forgetful* or *less on the ball* at this time were less inclined to attribute these changes to perimenopause. Only a few leaders ticked *problems with concentration* and/or *poor memory*. This outcome was surprising in that research indicates that around 60% of perimenopausal women report having problems with memory and concentration at this time (Luetters & Huang, 2007; Greendale et al., 2009). Discussion with the participants revealed that most of those who did notice changes in cognitive function attributed these to the normal process of ageing.

As mentioned earlier, a lack of awareness about the possibility of hormonally mediated cognitive or emotional changes may lead some women to suspect a more sinister reason for their symptoms (Boughton & Halliday, 2008). Leaders who notice changes in aspects of their cognitive function need to be informed that this is not necessarily an indication of a progressive age related decline but may occur for a short period during late perimenopause, after which time the problem may spontaneously resolve (Greendale et al., 2009).

It is vital that female leaders are provided with an opportunity to discuss any concerns about changes in cognitive function during perimenopause in a non-threatening and non-judgmental environment. Interventions of this nature may assist women leaders to more effectively manage this time of their lives without making significant decisions (including ones related to their careers) based on misconceptions about the symptoms they may be experiencing.

Erratic, loony and emotionally driven extreme behaviour.

Of particular interest in this study was the extent to which leaders reported experiencing what many described as *uncharacteristic* behaviour during perimenopause. The use of terms such as *loony*, *erratic* and *irrational* by leaders to

describe their behaviour indicates a deeper level of effect than is suggested by the terms *anxiety*, *irritability* and *mood swings* which are proffered on the symptoms checklist. One leader talked about her *emotionally driven extreme behaviour* and another talked about losing her *courage*. It was also interesting that a number of leaders reported a lack of insight at the time the uncharacteristic behaviour was manifesting. This was significant for many who expressed some consternation when reflecting back on their past behaviour. It was often only after commencing HRT and noticing a change in their emotional state that participants were able to evaluate the extent to which their earlier behaviour had been affected. For example, one leader who did not take HRT until leaving her employment, questioned whether the change in her emotional state that she had experienced while still in a leadership role may have precipitated her decision to take early retirement.

The confidence with which many of the leaders attributed the changes in their moods and emotional behaviour to hormonal fluctuations is supported by the research. Studies indicate that hormone fluctuations such as those often associated with the pre-menstrual and post-natal periods as well as during perimenopause can significantly affect emotional health, well-being and quality of life (Li, et al., 2000; Dennerstein, et al., 2002; Soares & Zitek, 2008). In fact, a number of leaders likened the experience to an extended and often severe period of premenstrual tension (PMT).

Although some early research (Huber et al., 1999; Robinson, 2001) suggests that mild forms of psychosis and even an increase in the incidence of schizophrenia may be related to perimenopausal changes, a search of the relevant data bases found no reference to the extreme changes in emotional and psychosocial behaviour described by a number of the leaders in this study. Anecdotally, erratic behaviour during the menopausal transition is not unexpected and many women can relate stories about their own or other's reflections regarding uncharacteristic or erratic behaviour at this time of their lives. Although it is questionable whether timely awareness may have enabled any of the leaders to adjust their reportedly uncharacteristic behaviour, one leader lamented the fact that no-one had made her aware at the time. She said she believed this would have been helpful.

For some leaders, particularly those working for large international corporations or in politics, feeling vulnerable and manifesting any sign of emotional instability was considered to be a threat to their credibility and potentially, to their leadership prospects. As one leader said: *It is okay to break a leg, but it is not okay to get a bit fed up*. For this reason, it is important that opportunities are provided for women in leadership roles to talk about these sorts of issues in non-threatening environments. In addition, raising awareness about the possibility of this kind of manifestation of perimenopause may ensure that women are able to address the problem at the time it is occurring rather than, perhaps, making career (and other) decisions that they may later regret.

Summary

It is evident that at the very least, perimenopausal symptoms can be disruptive and at their most extreme, have the potential to undermine a leader's capacity to maintain optimum work performance. It is unfortunate that the period of perimenopause when symptoms may be at their most severe so often coincides with the time in a female leader's life when she is striving to maintain and perhaps advance her career.

Female leaders who may be ill-informed and unsuspecting may be experiencing symptoms that have the capacity to undermine their confidence, performance and quality of life. This lack of timely awareness was raised by a number of leaders who claimed that recognition of symptoms was often retrospective. Furthermore, as with the similarly successful and highly educated women in Simon and Reape's (2009) study, many of the leaders in the current study were unclear about the risks and benefits associated with the use of effective treatments such as HRT.

As discussed earlier, research shows that women in general are ill informed about what to expect at this time of their lives. Women in leadership roles may be at a further disadvantage because the nature of their work often isolates them from other women and opportunities to share pertinent information about issues such as perimenopause. This issue of isolation forms the basis of Superordinate Theme Four and will be discussed later in the chapter.

It is evident once again that women (particularly those in demanding roles) will continue to be disadvantaged if they (and their doctors) are denied timely and effective education about the nature and onset of perimenopausal symptoms and the most effective and appropriate treatment options.

Superordinate Theme Two: Soldiering On or Taking Control

- Just get on with it!
- Time out.
- Seeking support
- I like my doctor
- I just don't like taking tablets
- Im dead or I'm on HRT

A number of factors reportedly influenced the decisions leaders made in regard to the management of their symptoms. Some indicated that the way they approached this time of their lives reflected the determination that had enabled them to achieve their leadership status. For others, decisions about managing symptoms were associated with their core beliefs about the use of medications or preference for *natural* therapies.

Just get on with it!

Many of the leaders approached the management of their perimenopausal symptoms with the same determination and professionalism that they applied to other aspects of their leadership roles. One leader said she believed she lost much of her *softness* at this time while others used terms such as *pushing through* or *soldiering on* to describe the way they managed unpleasant symptoms. Others described how adopting a *just get on with it* attitude took its toll on other aspects of their lives including their relationships with family members. One leader said she did not believe someone in her position should have *off days* and others described how their sense of being

motivated or *professional* prevented them from taking *sickies* or time off to seek professional advice about symptoms.

It is questionable whether such attitudes were beneficial to the leaders either in terms of their health and well-being or their capacity to maintain optimum work performance at this time. Endeavouring to maintain an aura of professionalism while contending with troublesome symptoms must constitute an added burden for anyone in a demanding leadership role.

Time out.

In contrast to the apparent impost often associated with the demands of a leadership role, some leaders discussed how their status also afforded them a degree of autonomy and flexibility. For some this enabled them to take *time out* both as a means of managing their symptoms and of avoiding scrutiny at times when they may have felt particularly vulnerable. A number of leaders talked about working from home; re arranging appointments or avoiding confronting situations at times when symptoms were problematic.

The degree to which leaders were able to take advantage of flexible working arrangements varied with many saying that the high work loads associated with their role made it difficult to take time off or avoid contact with others. Leaders in highly competitive corporate roles may have less flexibility than those in government or not-for-profit organisations in which there may be a more developed culture of ensuring some degree of work/life balance.

Seeking support.

Although many of the participants described a number of factors that they believed limited their opportunities to talk to significant others about issues associated with perimenopause, those who were able to talk to friends, colleagues, family members or health professionals found this to be a useful coping strategy.

In particular, a number of leaders who may otherwise have been quite isolated by their leadership roles described how they were able to achieve a degree of peer support by forming a social group outside their respective workplaces which they referred to as their *Menopause Support Group*. Although they did not all work together, they were peers in regard to their age and leadership status. They described how they met regularly and were able to offer each other advice and support as they entered and travelled through perimenopause. All indicated that this particular affiliation had been helpful at the time and was a source of both information and support for those involved. The success of this affiliation may provide some insight into the most effective ways to ensure that other female leaders are afforded similar opportunities for garnering support. It may be significant that the women did not all work together and were able to meet on neutral territory that provided a non-threatening and supportive environment.

The experiences of this particular group of leaders is in contrast to the experiences of other study participants who found that aspects of their leadership role often isolated them from possible sources of advice and support. As previously mentioned this issue of isolation is at the core of Superordinate Theme Four: *It's lonely at the top* and will be discussed later in the chapter.

I like my doctor.

During the interviews, many of the participants discussed aspects of their relationship with their doctor and how this influenced the way they managed their symptoms. Although most indicated that they liked their doctor and felt comfortable talking about various symptoms, this was not always the case. One described feeling less comfortable discussing certain issues with a male doctor and others had difficulty establishing a relationship with a new doctor when their usual doctor was no longer available. Even for leaders who believed they had a good relationship with their doctor, it was apparent that for some there was poor communication around the issue of perimenopause.

Participants were not asked directly about the gender of their doctor, however most mentioned that their current doctor was a woman. One leader said she believed it was important for women to establish a good relationship with a female doctor because they may not receive the same level of support around the issue of perimenopause from a male doctor. Although a number of leaders indicated that they may be more reticent about discussing certain issues with a male doctor, a number of those who had female doctors also indicated that there were issues such as libido, vaginal health or sexual function that they felt less comfortable discussing.

Participants discussed various aspects of the advice they had received from their doctor in regard to the treatment of perimenopausal symptoms. A number gave accounts of receiving advice which appeared to contradict that provided on the AMS website (www.menopause.org.au). For example, one leader who had commenced using HRT for troublesome symptoms, talked about discontinuing its use after experiencing unwanted side-effects including breast tenderness. It is now recommended that doctors experiment with different doses and modes of hormone delivery in order to find the treatment that reduces the incidence of symptoms such as hot flushes while avoiding side-effects such as breast tenderness or breakthrough bleeding (MacLennan, 2009). Furthermore, as previously mentioned, a number of leaders talked about being advised (contrary to AMS recommendations) to have blood tests purportedly to ascertain perimenopausal status when in fact the fluctuating levels of hormones associated with perimenopause mean that blood testing is frequently inconclusive at this time.

These findings suggest that it is likely that unless a general practitioner has undertaken post graduate training such as that offered by the AMS, he or she may be less effective at identifying, assessing and treating perimenopausal patients effectively. The AMS website lists doctors throughout Australia who have undertaken this training and women should be made aware of this information.

I just don't like taking tablets.

Although there is limited empirical evidence for the efficacy of complementary or alternative medicines (CAMs) to treat perimenopausal symptoms (Cutson & Meuleman, 2000; Hunter, 2003; Hickey et al., 2005; MacLennan 2009) a number of leaders reported achieving some relief from symptoms using these kinds of products. Other leaders talked about the benefits of maintaining their general health at this time, through diet, exercise and relaxation techniques such as yoga. Leaders used terms such as *ride it out* in regard to coping with symptoms rather than resorting to the use of products many referred to as *medications*.

A number of leaders expressed their reluctance to use pharmaceutical products generally while some were concerned specifically about the use of HRT. This concern was not surprising in light of the negative publicity about HRT which has resulted in many women choosing to discontinue using this treatment (MacLennan, 2009; Simon & Reape, 2009). Other leaders reported that their preference for non-pharmacological approaches was based less on concerns about the possible adverse effects of treatments such as HRT than on their belief that menopause was a natural process and (as one stated) should not be *tampered with*. This attitude was consistent with the findings of Bosworth et al. (2005) who reported that women who thought of menopause as *natural* were less likely to use HRT and more likely to discontinue using it after the highly publicized findings from the WHI report in 2002. They also found that women who thought about and understood the risk/benefits of HRT were more likely to start and less likely to discontinue using this treatment.

Although many of the participants said they had endeavoured to gather information about the safety and efficacy of the various treatment options, it was evident that some were reliant on the information promulgated in the media. Furthermore, according to MacLennan (2009) many health professionals continue to promote therapies including hormonal preparations (often referred to as bio-identical hormones) for which there is little quality control or evidence of efficacy or safety. MacLennan also claims that the risks associated with the use of HRT “have been inflated by the popular press and those purveying alternative therapies (p. 121).”

Although tighter restrictions on the promotion of alternative medicines have been recommended (MacLennan, 2009), the onus continues to be on health professionals to ensure they are well-informed about the efficacy and safety of the products they recommend. It is also imperative, given the research suggesting a critical period for initiating HRT, that women are provided information in a timely manner to enable them to undertake treatment early enough to achieve the most benefit.

I'm dead or I'm on HRT.

A number of participants talked about using HRT to *take control* of their symptoms. With the exception of one leader who experienced unpleasant side-effects (as discussed above) all participants who subsequently used HRT for extended periods of time found it effective for reducing their symptoms and many reported significant improvements in the quality of their lives. Some also stated that the use of HRT had improved their ability to cope with the demands of their leadership roles. The benefits associated with the use of HRT were summed up rather dramatically by one leader who said *I'm dead or I'm on HRT*.

Furthermore, although a number of leaders reported that their doctor had encouraged them to consider ceasing to use HRT after the recommended 5 years, some said they had ignored this advice and continued the treatment because it had greatly improved their overall quality of life. Many of the study participants who initiated HRT prior to 2002 had been using it for longer than 5 years, some only discontinuing use after retirement and one was still on HRT after almost two decades.

Summary

Participants chose different strategies to manage perimenopausal symptoms. In many cases, leaders indicated that their decisions to either *soldier on* or *take control* of symptoms reflected their general philosophical approach to the use of medications. Participants, who chose to *soldier on*, often reported using behavioural strategies, lifestyle changes and *natural* approaches to symptom management. Others indicated a

preference for *taking control* of their symptoms, with some choosing interventions such as medically prescribed hormone therapy.

Although there has been wide criticism of aspects of the WHI findings (Wren 2009; MacLennan, 2009) many women (and their doctors) may continue to be uncertain about the risks and benefits associated with HRT. In regard to the findings of this study, the decisions participants made about the management of their symptoms would be expected to reflect the broader community's changing attitudes and uncertainty about treatment options. Not surprisingly, the majority of leaders who had used HRT for extended periods of time had begun doing so prior to 2002 while of those who reportedly entered perimenopause after 2002 only one was using HRT at the time of interview. According to MacLennan (2009) HRT remains "the best researched and most effective management of both menopausal symptoms and the long-term consequences of estrogen deficiency (p. 116)." A number of eminent women's health specialists have recently raised their concerns about the ramifications for women of what they describe as unbalanced reporting about the risks associated with the use of HRT (MacLennan, 2009; Smith, 2010; Wren, 2009).

According to MacLennan (2009), "The risks of HRT have been inflated by the popular press and those purveying alternative therapies (p.121)." He provides the following recommendation:

The message is that the latest data on HRT do not warrant the fear and ultra-conservative approach adopted in 2002. Long-term therapy is appropriate for women with long-term symptoms who are aware of the potential risks of their regimen in their personal circumstances. (p. 121)

The change in attitude to the use of HRT may have left many leaders with few effective options for managing troublesome symptoms. It is not inconceivable that under such circumstances, some leaders may find it difficult to *soldier on* without the benefits of HRT. It is also possible that some may choose to relinquish their leadership roles or decide not to contest promotional opportunities as a consequence.

Once again, it is clear that education of women and health professionals about the risks and benefits associated with the various treatment options is critical if women are to be effectively supported through the menopausal transition. There appears to be no substitute for effective doctor-patient communication about current treatment options. In addition, the onus must be on health professionals to ensure that the information they dispense is up-to-date and that they are proactive in discussing perimenopausal changes with their women patients as they enter mid-life.

Superordinate Theme Three: Keeping Up Appearances

- Fronting up and putting on a bit of a face.
- Show your weakness and you are lost!

Maintaining a confident and professional demeanour was of great importance to the majority of leaders. In particular, leaders discussed two areas of concern: firstly the need to be present and appear to be fully functional at all times and secondly, the need to avoid appearing weak or vulnerable at any time.

Fronting up and putting on a bit of a face.

Leaders talked about having to *front up* and be seen as capable, competent and in control at work. This reportedly included being able to *function* and to *look neat and tidy and presentable all the time*. A number of leaders talked about the lengths they would go to in order to ensure they would be able to maintain (what they considered) the appropriate image at work. Strategies included being highly organised and maintaining an appearance of coping that they may not have managed to maintain in their private lives. There was often a sense of resignation as well as determination. One leader described herself as a *get on with it* sort of person while another talked about becoming more *matter of fact* about her work and other issues at this time.

Several aspects of experiencing perimenopausal symptoms (such as hot flushes) that had the potential to undermine this image were mentioned. For example the distraction often associated with being *dripping wet* as the result of hot flushes was seen by some as a potential threat to their ability to maintain an image of professionalism either because it caused them to lose concentration or because they believed it made them appear flustered or somehow less competent. Although most participants believed they were largely able to maintain their professional image while in the workplace, the effort often required to achieve this clearly constituted an additional impost on the health and well-being of these leaders at this time in their careers.

Show your weakness and you are lost!

Showing any degree of vulnerability was perceived by many leaders as a threat to their leadership status. A number of leaders talked about not wanting to be recognised as menopausal or experiencing perimenopausal symptoms because they felt they might be judged as less capable or competent. One leader talked about believing that others may make negative judgements about any woman who was seen to be *needing to resort to assistance* (such as using HRT). Another participant who worked in a predominantly male industry talked about how she made a distinction between revealing the physical versus the more emotional symptoms of perimenopause, believing she had to hide the later.

Another leader spoke about the importance of maintaining an aura of coping and approachability for the benefit of *reports* or other (usually subordinate) colleagues. This leader believed that revealing any level of personal vulnerability (such as that associated with having a hot flush) had the potential to compromise the level of confidence she believed others needed to have in her as a leader. Maintaining an aura of confidence was considered to be important if others were to continue to feel comfortable about seeking her guidance or support.

It was interesting to note that one leader who worked in a female-dominated workplace was more concerned about ensuring that those reporting to her continued

to feel confident in seeking her counsel while a number of leaders who worked in male-dominated professions were more concerned about the impact on them personally of being judged as less than competent. Although maintaining an aura of professionalism was important in both cases, the primary reason for doing so differed. This finding is consistent with the findings of a study by Gardiner and Tiggermann (1999) which, although somewhat dated, may unfortunately continue to be relevant for women in Australian workplaces today. Their research indicated that women adopt different leadership styles depending on the gender balance of their organisation. They found that women were less inclined to adopt the traditionally more feminine interpersonally orientated leadership styles when working in male-dominated environments than when working in more gender-balanced or female-dominated environments. Furthermore, they cite a study by Eagly and Johnson (1990) which showed that women working in male-dominated environments were more concerned about maintaining authority and position. Gardiner and Tiggermann noted that in Australia the majority of women in leadership roles worked in male-dominated environments and were therefore likely to be subject to a number of pressures and expectations that women in more gender balanced organisations did not face. Furthermore, they also noted that this gender imbalance often caused women leaders to feel more *visible* within the workplace and that this often engendered a sense of vulnerability.

It is unfortunate that this gender imbalance continues to be a factor in Australian workplaces (EOWA, 2009). In these environments, female leaders manifesting the outward signs of perimenopause or being distracted by symptoms that may impact on emotional or intellectual function could conceivably experience a heightened sense of visibility and vulnerability. This may be particularly the case for female leaders working in positions that place them under constant public scrutiny. Two leaders commented on the difficulties they and other women faced when their roles involved high profile exposure in the public arena. Both discussed how this increased their perceived need to maintain an aura of coping and competence at all times.

Leaders described the strategies they used to avoid placing themselves in the public arena when they felt that perimenopausal symptoms (such as hot flushes) may have put them at a disadvantage. One leader who worked in a highly competitive male-

dominated environment, also talked about how she believed she had to avoid showing any vulnerability and that she felt she needed to be *in her armour* in the workplace.

Another leader talked about her perceived need to be *like the men* she worked with which reflected the findings of Mavin (2008) who talks about the “continuing pervasiveness of heroic masculinity” (p. 76). This she says, requires that women adopt stereotypically male attributes, thereby risking censure from both male and female colleagues. Mavin suggests that this expectation that women should adapt their behaviour in this way may actually dissuade women from seeking positions of leadership. Furthermore she says that it is evident that “women’s presence in the world of men is conditional on their willingness to modify their behaviour to become more like men or to be perceived as more male than men” (p. 76).

Although one leader said she believed there were negative connotations within the pervading culture, about menopause being a time of aging and loss of sexuality, none of the leaders expressed concern that being recognised as menopausal may have led others to also perceive them (personally) as being old or ageing. It may be that a certain level of maturity is considered acceptable, and even perhaps desirable for anyone (male or female) when holding a position of leadership. A search of the literature failed to uncover any research into current perceptions about the relationship between age and leadership. It is evident however that with the average age of board director being between 51 and 70 years of age as discussed earlier (Kang et al., 2007), a degree of maturity is the norm and most likely expected of those in leadership roles. It is possible that the leaders in the current study did not perceive that there was a disadvantage for women in being recognised as menopausal and therefore, by association, ‘old’, as long as this was not considered to be synonymous with being less capable or competent.

Summary

It would appear that although many of the leaders indicated that they were not concerned if others identified them as being menopausal (as made evident by having a hot flush in a public setting) most were concerned about losing their poise and being

judged as less capable or competent as a result of their symptoms. It was also evident that a number of leaders made a distinction between the physical and emotional symptoms associated with perimenopause. As one leader put it ... *it is okay to break your leg but it is not okay to get a bit fed up.*

Leaders' efforts to avoid the possibility of being judged as emotionally or intellectually compromised because of perimenopausal symptoms often required the development of strategies to maintain their poise and aura of coping. These strategies ranged from choosing clothing to minimise the effects of hot flushes to avoiding public exposure at times when symptoms may have increased their sense of vulnerability.

Although such strategies were effective for some leaders, others indicated that the demands of their particular work made it difficult to accommodate the physical and emotional impost of certain symptoms. It is likely that women leaders in high profile roles involving frequent interface with the public, may find it particularly difficult to consistently maintain an aura of coping and competence while contending with troublesome perimenopausal symptoms. These women may be more inclined to relinquish their leadership roles than their counterparts in less high profile roles, if they are unable or unwilling to access effective treatment (such as HRT) for their symptoms.

Superordinate Theme Four: It's lonely At the Top

- No one to talk to
- A no-go-zone!

A number of aspects of being in a leadership role reportedly contributed to a sense of *isolation* for some participants. This was often related to the time demands associated with being in a leadership role and in many cases, the absence of female peers within the workplace.

No one to talk to.

In Australia, women in leadership roles continue to be in the minority in almost every sphere of industry (EOWA, 2009). It was not surprising therefore, that the majority of participants were either employed in male-dominated work environments or were required to report to boards which were male-dominated. According to Gardiner and Tiggermann (1999), women in mostly male workplaces often found that they were isolated from their male peers and therefore often unable to access both formal and informal support networks that men take for granted. With little change in the gender balance in Australian workplaces, this lack of supportive networks is still likely to be a major factor for most female leaders. Leaders experiencing perimenopausal symptoms may be particularly disadvantaged in these environments because they may lack opportunities to garner information and support from other women. In addition, the perceived need to maintain an image of approachability and/or competence (as previously discussed) may increase the sense of isolation for many female leaders.

As discussed earlier, those leaders who were able to establish peer support networks found this extremely valuable. Unfortunately, the majority of study participants reported that these kinds of opportunities were limited. For example, one leader who characterised the company she worked with as being *dreadful with its women*, described how this added to her level of anxiety particularly as she lacked female peers she could *relate* to and from whom she could seek support. Another talked about being *isolated away from* (subordinate) staff by virtue of her leadership status and therefore needing to seek support and mentorship from those *in line or above* whom she said *may not be thick on the ground*. The same leader also commented that in addition, there was a need to be able to *connect* with others and be prepared to share information with them. In this regard, she only felt comfortable talking about perimenopausal issues with colleagues who were also considered friends.

Other aspects of being in a leadership role may also cause women to feel isolated. For example, a number of participants talked about the long hours they worked and how this restricted the time available for socializing and sharing information outside the workplace. One leader felt that being in a management position restricted the time available to *chat* with others which caused her to feel isolated and prevented her from

talking about things that other women may have been experiencing. She said there was no *forum to communicate* for women leaders (like her) in the workplace.

Finally, in contrast to the perception that a more gender balanced or *feminised* workplace may be more supportive of women one leader indicated that she believed that women are not always supportive of each other in all circumstances in the workplace. She suggested that a supportive work environment has more to do with the personalities of those involved than their gender.

A no-go-zone!

Even when there were other professional women to talk to, a number of leaders did not believe it was appropriate to discuss personal issues such as perimenopause. One leader describes this as a *no-go-zone* and another as a *totally taboo subject*. Similarly, another leader said that for her, any discussions of issues such as perimenopausal symptoms with female colleagues would be *fairly brief and superficial*.

Interestingly, another leader made the observation that a lack of understanding may reduce people's tolerance to the mood changes often associated with perimenopause. She said that others may react better if they were aware of the reasons for the change in behaviour of a female colleague rather than believing she was simply in a *bad* or *snooty mood*.

Summary

Although leadership may be an isolating experience for both men and women, it is apparent from the extant literature such as Gardner and Tiggemann, 1999, and the findings of this study, that women leaders are further disadvantaged because they are often in the minority and frequently excluded from the networks that their male peers use to garner support. For women experiencing troublesome perimenopausal symptoms, this lack of support may have particular significance if it prevents them

from accessing opportunities to normalise their experience or share advice about symptom management.

In addition to being *thin on the ground*, as one leader put it, the long working hours may further limit the opportunities for many female leaders to access and share information and support both within and outside the workplace. Furthermore, a number of study participants reported that aspects of their experience of perimenopausal symptoms caused them to feel more physically and emotionally vulnerable. This increased sense of vulnerability may be further exacerbated by their isolation.

Recommendations and Other Issues Raised by Participants

The majority of leaders discussed the need for more comprehensive education of women in regard to the recognition and management of perimenopausal symptoms. It was also suggested that health care professionals should be better informed in order to be more effective in offering appropriate and timely advice. One leader specifically mentioned that she believed women are more likely to receive good advice and effective treatment if they are able to establish a good relationship with a female doctor.

Although several leaders mentioned the potential benefits of effective mentoring and advocacy for female leaders generally, there was often the perception that there may be barriers to discussing *personal stuff* in these kinds of forums. A number of leaders also mentioned that it may not be appropriate to proffer advice (particularly when unsolicited) about perimenopause or coping with symptoms to colleagues.

An anticipated outcome of this research was that participants would provide specific advice or recommendations that may benefit other leaders in similar situations. It was therefore surprising that very few suggestions were put forward during the interviews. After reviewing the findings however, it became clear that the issues that contribute to the feeling of isolation that many female leaders described may also restrict the opportunities available for garnering support and information. It was also apparent

that the need to maintain an aura of coping and poise appeared to be at odds with the concept of having open discussion within the workplace, about issues associated with perimenopausal symptoms. Within this context, leaders may have found it difficult to envisage specific interventions or strategies that may have provided support to others in similar circumstances.

One leader did however mention that she thought that *good stories from women* may be a valuable way to provide other female leaders with information and advice that is relevant to their unique situation. The sharing of personal experiences by female leaders may assist in reducing the stigma associated with this issue and enable others to gain the insight and support necessary to more effectively manage this time of their lives and as one leader said, *survive wonderfully*.

Chapter Six: Conclusion

The findings of the study will now be summarised and conclusions drawn. In addition, the limitations of the study will be outlined and recommendations for effective interventions and further research will be presented.

At the outset of this study, several issues considered to be at the core of this research were outlined:

- Most women will experience perimenopausal symptoms.
- Many women are ill-informed about the nature, onset and effective management of perimenopausal symptoms.
- Perimenopausal symptoms have been shown to cause a range of physical and emotional symptoms for women in the workplace.
- The work environment has been shown to exacerbate the effects of perimenopausal symptoms.
- Perimenopausal symptoms may constitute an added burden for women contending with certain demands reportedly associated with leadership.
- The age at which women are likely to be undertaking leadership roles often coincides with the age at which many may be experiencing perimenopausal symptoms.
- A loss of confidence in the use of HRT may have left some women leaders with limited treatment options for problematic symptoms.

Although there is research supporting the tenet of each of these core issues, few studies have investigated the effects of perimenopausal symptoms on women in leadership roles. This study sought to explore this phenomenon by providing a representative group of women leaders with an opportunity to relate their experience of perimenopausal symptoms; how they managed their symptoms; the factors that influenced their decisions regarding treatment options and their recommendations for other women in similar circumstances. Information was gathered through in-depth, semi-structured interviews with 17 women leaders.

Interpretative phenomenological analysis (IPA) was chosen for this study because of its capacity to ensure that participants' responses were not limited by narrow predefined parameters (Smith et al., 2009). The following four Superordinate Themes were subsequently identified, each reflecting both the commonalities and differences within the reported experiences of the participants:

- Distraction, disruption, discomfort and distress
- Soldiering on or taking control
- Keeping up appearances
- It's lonely at the top

These emergent themes reflected the particular set of circumstances that confronted the women leaders who participated in this study. Many of the issues raised provide new and often unanticipated insights into how women leaders may experience perimenopausal symptoms and the implications in regard to their professional roles. For example, participants reported that experiencing perimenopausal symptoms while contending with the demands associated with a leadership role was often distracting, and for some, a source of physical and emotional distress which had the capacity to undermine confidence and work performance. Although perimenopausal symptoms have the capacity to adversely affect women in general, a number of factors associated with both the status and work demands experienced by women in leadership roles may exacerbate their experience of symptoms and compromise their capacity to maintain optimum leadership performance.

Furthermore, a number of leaders in this study indicated that there may be ramifications for women who display any signs that perimenopausal symptoms may be having an adverse affect on their level of performance or capacity to do their work. This may contribute to the reluctance many leaders expressed in regard to publicly acknowledging their symptoms or discussing their experience with their peers.

Of particular significance in this study was the concurrence of the age at perimenopause with the age at which women may be undertaking leadership roles. Many of the study participants described having to contend with troublesome

perimenopausal symptoms while also facing a range of challenges specifically associated with being a female in a leadership role. For example, many described the isolation they experienced in regard to working in largely male-dominated environment. The gender imbalance that continues to be a factor for women leaders in Australian workplaces has been shown to increase the stress levels of many women leaders who may feel overly visible and vulnerable as a result.

The lack of female peers also reportedly limited the opportunities for female leaders to seek advice and support in relation to both professional and personal issues. In addition, a number of study participants indicated that the time demands associated with leadership roles also limited opportunities for socializing outside the workplace. This may have further restricted opportunities for gathering information, advice and support from other women and health professionals.

Another issue that may be of particular significance for women in leadership roles is the change during the past several years, in attitudes to the use of HRT. A number of studies indicate that negative publicity has caused many women to avoid using HRT (Holloway, 2009; Simon & Reape, 2009; Wren, 2009). This is disturbing because HRT remains the most effective treatment available for the management of perimenopausal symptoms (MacLennan, 2009) and recent reports indicate that for many women, low-dose HRT commenced around menopause and used for up to five years may actually be beneficial and pose few health risks (MacLennan, 2009; Wren, 2009).

The changing attitude to the use of HRT was evident within this study with leaders who entered perimenopause in the pre-WHI era were more inclined to use HRT than those who entered perimenopause more recently. Furthermore, many of the leaders who used HRT to manage symptoms reportedly believed that the treatment enabled them to continue to manage the demands of their work and, for some, to achieve a better quality of life. The change in attitude to the use of HRT may mean that some women leaders are less comfortable about using this treatment and therefore left with few effective options to manage troublesome symptoms.

Women generally need to have access to information that will enable them to make informed decisions about treatment options. Health professionals including mental health counsellors such as those employed in employee assistance programs, are well placed to provide this kind of information and support. Simply raising the possibility that physical and emotional changes may be the result of the hormonal fluctuations often associated with perimenopause, may enabled women to take control and actively manage their symptoms. This information may also greatly reduced their anxiety that certain symptoms may herald the onset of some more sinister illness or indicate the beginnings of an age-related decline in cognitive function.

It has been suggested that raising awareness about the possible impact of perimenopausal symptoms on the work performance of female leaders may in some way further disadvantage women. Although there is the possibility that this may be the case, it is imperative that women are informed about the nature and onset of possible symptoms so that they can make the most appropriate decisions about how they manage this time of their lives.

It is evident that women in leadership roles within Australian workplaces are likely to be in the age range in which they may experience perimenopausal symptoms. Many will be ill-informed about the nature and onset of symptoms and the effective treatment options available. In addition, the demands of their professional roles may restrict their opportunities to gather and share information with their peers and health professionals. Furthermore, women leaders may have to contend with the added burdens associated with working in male-dominated environments where they are often isolated from other women and the support networks that may be available to their male colleagues. It is likely that the combination of these factors may constitute a major challenge for women who are striving to maintain optimum performance in leadership roles in Australian workplaces.

This study provides a number of insights into a previously unexplored phenomenon. The findings indicate that certain perimenopausal symptoms have the capacity to adversely affect women undertaking leadership roles. Denying that this may be an issue for some women leaders may be counterproductive and contribute even more to the sense of isolation that many of the study participants reportedly experience around

this issue. This study provides a clear mandate for the development of strategies that provide opportunities for leaders to share information and concerns with their peers, about perimenopausal symptoms and other issues that may be unique to women in leadership roles in Australian workplaces. Providing the kind of information and support that enables perimenopausal women to take on and continue to meet the challenges associated with a leadership role, will be of benefit to the women, the business world and the community in general.

Limitations of the Study

As outlined in Chapter Three, the intention of this study was to explore the lived experiences of a particular group of women in order to develop a greater understanding of the phenomenon under investigation. The study participants represent a unique group of women who shared a relatively unique set of circumstances related to their working lives. In this regard, the findings of the study are not intended to be transferable to other populations but may nevertheless be used to inform the direction and nature of further research and guide the development of effective interventions for women in similar circumstances.

Further Research

The value of conducting further research into the effects of perimenopausal symptoms on women in leadership roles is significant. The findings of this research provide the basis for a number of possible research projects.

Firstly, it would be valuable to investigate the current level of awareness among women in general regarding the nature and onset of perimenopausal symptoms, the various sources of information and support and their attitudes to the treatment options available. Secondly, further investigation is warranted into the needs of women in leadership roles in regard to the development of effective mentoring and support programs. Although there are a number of initiatives directed at enhancing the opportunities for women to access mentoring programs in relation to work

performance and skills, it is clear that there are barriers to open discussion of issues associated with the impact of hormonal fluctuations associated with perimenopause. Finding the appropriate strategies and approaches to overcome some of the stigma associated with this issue will be a challenge. Investigating effective ways to incorporate awareness raising and educational strategies into existing occupational health and safety and professional development programs through business organisations and professional groups may provide the impetus for a change in attitude to an issue that has hitherto been avoided.

Another area for further investigation is the level of knowledge regarding the onset and nature of perimenopausal symptoms and the efficacy and appropriateness of treatment options amongst health professionals. It appeared in the leader's responses that information from health professionals was often limited and at times inconsistent with the advice provided by the AMS which is the peak medical body in Australia in regard to this issue. It would also be useful to investigate the degree to which the various undergraduate and postgraduate medical and counselling programs focus on providing this information to students.

Further research into these issues would contribute greatly to the body of knowledge in this area and subsequently the development of effective interventions directed at improving the circumstances of women leaders at this time of their lives.

Recommendations.

There are three recommendations based on the findings of this study. Firstly, it is evident that there is a need for more timely and comprehensive education of women in general in regard to the onset and nature of perimenopausal symptoms. It is recommended therefore, that women should be advised that perimenopausal symptoms may begin several years before actual menopause and can adversely affect their physical and emotional well-being. Education needs to be directed at women in their 30s and 40s before they enter perimenopause. Secondly, special consideration needs to be taken in regard to the particular circumstances of women in leadership roles. This unique group of women should be provided with opportunities to access

information and support through existing occupational health and safety, mentoring and professional development programs in a manner that is non-threatening and respectful of the potentially sensitive nature of the issue. Thirdly, there needs to be an increased onus placed on health care professionals including occupational health and safety personnel, mental health counsellors and medical practitioners to provide the information and support that will benefit women approaching mid-life (and particularly those in leadership roles). This information should enable women to be prepared for the onset of perimenopause, recognise perimenopausal symptoms and make informed decisions about the management of their symptoms. Above all, this should be done in a timely and sensitive manner.

It is also evident that health care professionals are not always well informed about the health needs of women at mid-life. This information should be provided to students and through the professional organisations responsible for the ongoing education of health professionals. A greater onus should be placed on these professional organisations to ensure that their members are provided with up to date, peer reviewed information.

In addition, health care professionals need to provide women with the information and support that will enable them to maintain their postmenopausal health and well-being thereby improving their opportunities to extend their productive working lives if they so choose.

APPENDICES

APPENDIX A: CONSENT FORM



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CONSENT FORM

Respondent:

I hereby consent to participate in a study to be undertaken by Philippa Gavranich, Professional Doctorate (Health Science) student, University of Notre Dame Australia.

I have read the information sheet and understand what my participation in the study will involve. I understand that I may withdraw my consent and discontinue my participation at any time. I agree to the interview being tape recorded, transcribed, and the information being used for the purpose of the study, dissertation presentation at the University of Notre Dame Australia, and subsequent presentations including conferences, public forums or media releases. I understand that I have the right to review, edit or erase the recording or transcript of the recording of the interview prior to its inclusion in the study.

Signature.....

Date.....

Researcher:

I hereby certify that I have provided the respondent with the appropriate information about the nature of the study and the extent of her participation. I have also explained how the information will be used and that confidentiality will be strictly respected. I have answered any questions that have been raised, and have witnessed the above signature.

Signature.....(Philippa Gavranich)

Date.....

APPENDIX B: INFORMATION FOR STUDY PARTICIPANTS



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INFORMATION SHEET FOR STUDY PARTICIPANTS

This study is part of a Professional Doctorate (Health Science) being undertaken by Philippa Gavranich, student, University of Notre Dame Australia. The purpose of this study is to investigate the perceived impact of perimenopausal symptoms on women in leadership roles. In particular, it will explore how they cope with symptoms, the factors that influence their decisions regarding treatment option and their recommendations for educational and support services that may assist other women in similar circumstances.

- Participants will be volunteers who have been informed about the study and consider themselves eligible.
- Information will be gathered from participants during a tape-recorded, 60 minute, one-on-one interview conducted by the researcher in a private setting.
- Participants may withdraw consent and discontinue participation at any time during the interview.
- Transcribed information from the recorded interview will be used for the purpose of the study and dissertation presentation at the University of Notre Dame Australia and possibly in subsequent presentations and papers.
- The information gathered will be treated in the strictest confidence, in accordance with the requirements of the University Research Ethics Committee.
- Transcripts will contain no information that will enable identification of the interviewee or any other party.
- Participants will be given the option of reviewing the transcript of their interview.
- All tape-recordings and transcripts of interviews with participants will be held in a locked cabinet in a secure location, until the completion of the study to ensure the integrity of the data.
- On completion of the study, all transcripts will be held in a secure location at the University of Notre Dame Australia for five (5) years.
- Participants will be provided with an executive summary of the research findings at completion of the study.
- Participants will be provided with a list of contacts and resources that may answer any questions regarding the subject under investigation.
- Participants may contact the researcher, Philippa Gavranich on her mobile: 0418 901864 or by E-mail: pgavranich@student.nd.edu.au at any time if they have any concerns or queries. Alternatively, participants may contact research supervisors Prof. Helen Parker at hparker@nd.edu.au or Dr Sue van Leeuwen at Sue@leadershipwa.org.au or the Executive Officer of the Ethics Committee, University of Notre Dame Australia (08) 9433 0555 if they have any concerns or complaints about the process used in information gathering, the study or any aspect of their involvement.

Philippa Gavranich

APPENDIX C: INFORMATION ABOUT TERMS USED IN THIS STUDY



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Information about terms used in this study

There is often some confusion about the terms 'menopause' and 'perimenopause'. The term 'natural menopause' refers to the permanent cessation of menstruation resulting from the normal loss of ovarian follicular activity. Natural menopause is recognized to have occurred after 12 consecutive months of amenorrhea (no periods), for which there is no other obvious pathological or physiological cause. Menopause is therefore actually a point in time which is known with certainty only in retrospect a year or more after a woman has had her last natural period. The average age at which women reach menopause is 51 years.

It is estimated that around 80% of Australian women at mid-life, experience symptoms associated with changing levels of reproductive hormones. These symptoms are often most severe during the period of perimenopause which may begin as early as 15 years before, and for a year or more after actual menopause.

For more information about perimenopause and menopause see the website for the Australasian Menopause Society at www.menopause.org.au and their recommended links.

For the purpose of this study, the term 'leadership role' will be defined as follows:

A role in which an individual may exert influence over other people for the purpose of achieving organisational goals.

APPENDIX D: SYMPTOMS CHECKLIST



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Symptoms Checklist

The following 'checklist' is a composite of lists available from the Australasian Menopause Society (AMS) website and the 'Symptoms Checklist' used by the Rosalie Golan Centre for Women's Health in Subiaco (WA). Please indicate if you have experienced any of these symptoms.

Symptom Checklist	√
Hot flushes	
Light headed feelings	
Headaches	
Irritability	
Depression	
Unloved feelings	
Anxiety	
Mood swings	
Sleeplessness	
Unusual tiredness	
Unusual backache	
Unusual joint pains	
Unusual muscle pains	
New facial hair	
Dry skin	
Crawling feelings under the skin	
Less sexual feelings	
Dry vagina	
Uncomfortable intercourse	
Urinary frequency	
Poor memory	
Palpitations	
Loss of bladder control	
Breast soreness	
Fluid retention	
Abdominal bloating	
Migraine	
Sugar craving	
Problems with concentration &/or memory	
Night sweats	
Unusually heavy periods	

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