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An interpretative phenomenological analysis of post-menopausal women's experiences of the menopause, its impact on their relationship and intimacy, and their coping methods

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Abstract

Background: The menopause is a time when women's sexuality and sexual relationships can change because of the physical and psychological changes which occur. The number of post-menopausal women is rising and the proportion of their life which is lived post-menopause is also growing because of increased life expectancy. A literature review showed that there have been few qualitative studies of the sexual well-being of women in the menopause in terms of interpersonal relationships and the interaction of biological, psychological and social factors.

Aim: To explore post-menopausal women's experiences of the menopause, the perceived impact which it can have on their interpersonal relationships and intimacy, and the coping methods which they used.

Methods: Semi-structured in-depth qualitative interviews were conducted with 14 post-menopausal women aged 47-60 who had experienced natural menopause and lived in different cities in the UK. Data were analysed following the procedure for IPA.

Findings: Five superordinate themes were developed: sexual changes during the menopause; coping methods for sexual changes; menopause, men and relationship; managing menopause symptoms; and the meaning, knowledge, talking about the menopause and influence of the menopause on women's life.

A strong link was found between the menopause and the sexual changes experienced by the participants. Most participants had experienced many sexual changes. They used different coping methods to manage their sexual changes and tended to exhibit a negative attitude towards using medicine in general. All participants believed that the menopause had a huge impact on their relationships. Many participants reported using a variety of methods to deal with the menopausal symptoms and that they did not have sufficient knowledge about the menopause.

Conclusion: These findings demonstrate that the menopause is better understood in the context of women's lives interpersonal relationships, intimacy and many other aspects of women's lives.

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*Everything we see in the world is the creative work of women.
Science is the most reliable guide in life.
The biggest battle is the war against ignorance.
People who know that they will not be able to rest along the way
when they take a path will never get tired.*

Mustafa Kemal Atatürk

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Abbreviations

GP	General Practitioner
GSM	Genitourinary syndrome of menopause
HRT	Hormone Replacement Therapy
IPA	Interpretative Phenomenological Analysis
NHS	National Health Service
NICE	The National Institute for Health and Care Excellence
ONS	Office for National Statistics
SWAN	Study of Women's Health across the Nation
VMS	Vasomotor Symptoms
VVA	Vulvovaginal atrophy
WHO	World Health Organisation

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PREFACE

Menopause is a biopsychosocial phenomenon which can significantly affect a woman's life in many ways (Hakimi et al., 2016). Even though all women experience the menopause, it can be perceived and experienced differently by women depending on their culture, education, socio-economic status, past life and lifestyle (Anderson et al., 2004; Stewart, 2003). The menopause is a time when women's sexuality and sexual relationships may be altered because of the physical and psychological changes which occur (Feltrin & Velho, 2014). This is important because sexuality is a key part of our identity. According to the World Health Organization (WHO) (2006), sexuality is part of our identity. Sexuality is different and specific for each individual: it is an important part of who we are. Sexuality is not just a physical experience; it is our feelings, thoughts and behaviours which we have towards other people. We can find others physically, sexually and emotionally attractive, and all of this is part of our sexuality. Sexual relationships as one part of our sexuality are important for people across the lifespan. A satisfying sexual relationship positively affects the individual's sense of self and general well-being (Hinchliff & Gott, 2004).

The number of women living in the post-menopausal period is rising and the proportion of their life which is lived post-menopause is also growing as a result of increased life expectancy. This suggests a need to better understand how women perceive and experience their menopausal changes as impacting on their sexuality and sexual relationships and how they deal with this. This thesis describes a qualitative research study which explored post-menopausal women's experiences of the menopause, the perceived impact which the menopause had on their interpersonal relationships and intimacy, and their ways of coping with this impact.

The researcher's background and rationale for this study

Before I describe the structure of this thesis, I shall briefly introduce myself and summarize my interest in the subject, that is, my decision to start to research menopausal women. I think that there was more than one factor among the reasons why I wanted to make my PhD topic with women in the menopause period. Among these, I believe that my professional experience, social and cultural environment, my upbringing, academic knowledge and observations all had an influence.

I have a characteristic of perceiving and determining how to talk about unspoken topics as a person, to realize which subjects people do not take a stand on, and to show that they are actually important topics which are worth talking about. First, I want to start by talking about my education and explain where I stand on women's health. I took the high school exam and I won a place in the midwifery department of the health high school (an education which is spread over four years) at the age of 13. I started to learn, experience and think about women's health throughout my health high school years. Since then, I have tried to give helpful answers to the questions put to me by the people around me and to give them the right direction and the most correct information possible.

I graduated from health high school in 2006 as a midwife. In that year, I took the university exam which is compulsory for entering the University to improve myself and learn more about my field. With a high score in my field, I won a place in the Hacettepe University nursing department (five years of compulsory university education in total; one year only for learning English and four years for a Bachelor's degree), which was my first choice because this university only admits the students with the highest scores.

Among all the courses in my university life, the one which most attracted my attention was Women's Health, and I saw this course as a guide to understanding myself and the women around me and I was happy to study this course. This situation, in fact, can be seen as a sign that women's health was to be at the centre of my work from those years on. I graduated from the university as a nurse in 2011.

In the nursing education system in Turkey, there are fields for studying for a master's degree (with a minimum duration of two years), one of which is Obstetrics and Gynaecology Nursing. I wanted to place myself high in this field and prepare myself for research at the level of a doctorate and improve myself in this field. I started my master's education in 2014 after getting sufficiently high scores in the exams which I needed to meet the high licence requirements. Since I was the only student in the field of Obstetrics and Gynaecology Nursing at the university that year, I carried out the majority of the presentations and projects alone. In master's level education in Turkey, you have to prepare and explain most of the lessons in your own department to the lecturers, and this improves your presentation skills and teaching direction. During this

period, while I was improving this aspect of my skills base, I also increased my knowledge of women's health issues.

While my school life was continuing, my work life actually started because after I graduated from high school, I started to work in the largest and oldest women's health and maternity hospital in Turkey in 2007 as a result of the diploma which I had received after my success in the civil service exam. I worked there for many years. My work life and my education life together gave me the opportunity to compare the practical and theoretical knowledge of my subject and enabled me to look to the future with a more realistic perspective.

What I have seen from internships and lessons throughout my school life as well as in my ten years of working life made me think that the menopause, one of the most important points of women's health, was not emphasized. Priority was given to giving birth and the postpartum period in general. I realized that the women around me lacked information about the symptoms which they experienced and about how they should deal with the many changes which they experienced, and how much this situation will continue and what is caused by the menopause. I observed that women were also concerned about how the changes in their lives had affected them, and that they were hesitant when asking questions, especially about close relationships.

Moreover, as far as I can see from my observations, experiences and literature reviews, the health systems which I have worked in are not sufficiently accessible to women undergoing the menopause and adequate support is generally not provided. Only a small percentage of women receive adequate support during the menopause and seek solutions to their problems. It can be seen that women with menopause have difficulty resolving their problems and symptoms on their own and feel alone and in a difficult period. This can cause the negative effects of menopause, which is a long and difficult period which can threaten women's health, not only physically but also mentally. The increase in life span means that the years which women will spend living with the consequences of the menopause will naturally increase. It is therefore necessary to conduct studies of women in the menopause period in order to identify the issues on which women should receive support. I therefore decided to study the menopause for my doctorate so that I can shed light on an important issue which is both understudied and not talked about in practice.

I believe that the menopause is one of the most significant milestones in a woman's life, along with giving birth and dealing with the postpartum period, and it is important to acknowledge that. In line with my readings and experiences, both professional and personal, I realized why and how the close relationships of women in the menopausal period are affected and that this subject has hardly been mentioned in qualitative studies, which greatly influenced my choice of this thesis topic.

In my exploration of studies in this field, I was confronted with quantitative studies and studies specifically in the field of medicine, which encouraged me to conduct a qualitative study in order to understand women's experiences more fully. In addition, I chose to employ Interpretative Phenomenological Analysis (IPA) because it would give me the opportunity to understand the personal meaning of the menopause for the participants. I wanted to understand not only the biological effects of the menopause, but also the way it can impact on women's lives, mostly their close relationship, how the symptoms are intertwined with each other and their ways of dealing with difficult menopause and relationship issues in order to advance the knowledge and thoughts about the menopause for health professionals. As a woman, a midwife and nurse who has been interested in women's health since an early age, the topic which I explore in this thesis aligns very much with my knowledge, experience and interest on this subject.

The structure of the thesis

The thesis consists of seven chapters which are structured in the following way.

In Chapter 1, the Background chapter, I explore the contextual knowledge of the thesis by presenting insights into the many aspects of the menopause. First, the social context of the menopause, sexuality and sexual function, and social expectations are discussed. Then I shall consider the positive side of the menopause, factors affecting the experience of menopause and cultural differences in other countries towards the menopause. After that, I shall describe what the terms used during the menopause mean to provide general information on the menopause and the symptoms which are frequently seen during the menopause. Finally, I shall describe the general information about the menopause and ways in which it is treated.

Chapter 2 is a literature review. I shall describe the literature search, the review and its results. The review comprises a scoping review and a description of the search methods, the inclusion and exclusion criteria, the literature search strategy, data management and extraction, the data analysis and the findings. The results of the literature review are set out in two parts, qualitative findings from seventeen sources and quantitative findings from twenty-seven, and these are presented under six main themes from the qualitative studies and five main themes from the quantitative studies. The aim and objectives of the thesis are stated at the end of the chapter.

In Chapter 3, the Methodology chapter, I shall describe the IPA approach adopted for this thesis and explain the reasons why it is suitable for exploring this topic. I shall give a description of the qualitative paradigm and a summary of the meanings of ontology, epistemology, axiology and methodology. Alternative methodologies which were considered and rejected are also discussed in this chapter.

In Chapter 4, Methods chapter, I shall describe and justify the method used to collect data, the sample, the recruitment process and the data collection and data analysis steps. I shall also discuss the appropriate ethical considerations.

In Chapter 5, Findings chapter, I shall present the findings which emerged from the analysis of the data. I shall develop five superordinate themes: sexual changes during the menopause; coping methods for sexual changes; menopause, men and relationship; managing menopause symptoms; and the meaning, knowledge, talking about the menopause and the influence of the menopause on women's life.

In Chapter 6, Discussion chapter, I shall discuss the findings in the light of the relevant literature. I shall explain the theoretical and methodological contributions of this thesis to knowledge. I shall also reflect on the whole process and the findings and then discuss the strengths and limitations of this thesis.

In Chapter 7, Implication, recommendations and conclusion chapter, I shall first consider the implications of the findings and the recommendations which can be made for practice and policy; for information, training, education and support for menopausal women; and for future research priorities. I shall also pass on advice from the participants. The chapter will end with a brief concluding section.

CHAPTER 1: BACKGROUND

Introduction

In this first chapter, I shall present deep information covering all aspects of the menopause and the factors which have an impact on it. First, I shall explore the social context of the menopause. Then I shall explain sexuality, sexual health, sexual function, sexual dysfunction and how women are affected by them. After that, I shall emphasize gender and ageing around social contexts and relationships. Finally, I shall present a summary of social expectations around sexuality from older and menopausal women.

Undoubtedly, knowing why and how the menopause is positive for women is included in the discussion because it will provide important information about the need to pay attention to the positive aspects of the menopause because it is the negative aspects of the menopause which are most often mentioned. In addition, in this chapter, I shall try to explain the factors such as cultural and social impacts which affect the menopause experience beyond thinking that the menopause experience is only a consequence of decreasing hormones. I shall also discuss in this chapter that there is an important relationship between sexual life and the menopause and the factors affecting it.

Throughout the following text, I shall provide general information about the menopause, including some statistics, and explore what the menopause means. Following this, I shall present what the terms used to describe what happens during the menopause mean in order to provide a general background to menopause definitions of the terms used. These terms include what menopause means, the types of the menopause and the symptoms of menopause. I believe that it is necessary to be generally aware of both biological and psychological changes in order to fully understand the menopause and see its effects, so understanding the symptoms is particularly important. After describing the symptoms, I shall discuss how women generally cope with them, which methods they use and their beliefs about their efficacy.

1.1 The social context of the menopause

Menopause and the transition to the menopause are related to many different health issues. Although it is important to understand the physiology, the menopause should be seen as a bio-psychosocial process which needs to be understood from its psychological and cultural conditions. Cognitive behaviour and cultural patterns have an effect on how to perceive and combat what are defined as disturbing experiences of women's middle life as a life stage (Spiers, 2013).

Most women are more interested in biomedical information in order to understand the menopause (Spiers, 2013). The meaning of the end of menstruation actually shows a woman's interpretation of this transition process which she experiences and how she evaluates it. Peri-menopause and the menopause can vary from woman to woman both physiologically and psychologically. Cultural stereotypes encourage negative thoughts about the menopause and middle life (Spiers, 2013).

Throughout the twentieth century, the menopause was seen as a hormone deficiency. Looking at the menopause only physiologically and biochemically through changes in hormone levels might prevent the social context of the menopause from being seen (Ballard, Kuh, & Wadsworth, 2001). The historical and social structure causes important interactions for women in the menopausal period of the menopause experience. The social context has been examined in two different ways and the results have shown how social contexts affect the menopausal experiences of women. The relationship between health problems, marital and family problems and the experience of the menopause was examined and it was found that these stressful life events were seen as more important than the menopause experience itself. In addition, it has been reported that the menopause affects marriage and family problems. Second, the impact of the cultural and medical construction of the menopause on women's menopausal experiences was examined through how family members around a menopausal woman perceive and react to the menopause and it was found that the negative cultural and medical formations of menopause affect the menopause experience of the woman (Winterich & Umberson, 1999).

The socio-cultural perspective associated with menopause was developed in the 1970s by feminists, sociologists and anthropologists to counter the predominance of medical modeling (Hunter & O'Dea, 1997). The socio-cultural evaluation of the

menopause has, however, remained in the shadow of being seen as a physiological event and has not received enough attention; in other words, the socio-cultural aspects have not received as much attention as the biomedical aspects (Collins & Institutet, 2014). In many societies, the menopause is regarded as a turning point and a deterioration in a woman's life. Depending on the socio-political and economic order and the living conditions which it imposes on women, the results of reaching the menopause vary between societies (Kelly, 2011).

Cultural beliefs, values and attitudes towards the menopause determine the individual experiences of women going through the menopause in both positive and negative ways. Attitudes and beliefs about menopause show differences both in the historical context and between different cultures. As a result of cross-cultural comparisons, it has been observed that the types and intensity of symptoms observed vary considerably between countries. Significant differences have also been observed in different ethnic groups in terms of the patterns and prevalence of menopausal symptoms within the same country (Collins & Institutet, 2014). For example, hot flushes vary in intensity and have a bodily reality of social significance (Hunter & O'Dea, 1997). Hot flushes are common in 70% of Caucasian and Afro-Caribbean women but a less common symptom in Japanese and Chinese women. The underlying reasons for this anomaly can be considered to be both cultural and dietary (McVeigh, Guillebaud, & Homburg, 2008). To put it another way, the state and level of the menopause symptoms are involved in a biological, social, cultural and psychological process which can vary across cultures and, in addition, over time. Beliefs and attitudes have a great impact on the experience and perception of menopausal women (Kelly, 2011).

There are differences in the language used among women when describing the symptoms and between the related subjects in terms of reporting the experienced symptoms, and there are some external factors which can affect this such as changes in the design of studies, the methodologies used and women's diet and lifestyle. These differences can lead to difficulties in determining the cultural and biological causes of the symptoms (Collins & Institutet, 2014). Social norms also shape the way in which women view life, such as attitudes to sexuality and reproduction (Dillaway, 2012). The social context in which a woman lives is also necessary for her to understand the transition of the menopause (Jones et al., 2012).

1.2 Sexuality and sexual health

Although the menopause is a natural phenomenon experienced by all women, it can have an effect on their sexuality and sexual response (Basson, 2005). Sexual dysfunction can occur during the transition through the menopause, mainly due to changes in hormones. Women's sexual dysfunction is a multi-cause and multi-dimensional problem (Ambler, Bieber, & Diamond, 2012). A clinically significant relationship has also been found between the attitude of women to the menopause and sexual dysfunction (Nappi et al., 2001).

This implies that the menopause can have a significant impact on women's sexual and intimate relationships. The terms 'sexuality' and 'sexual health' are frequently used interchangeably in articles included in the literature review. Knowing the general definitions of these terms is important for understanding the subject. Sexuality is not just associated with reproduction, but is an important component of quality of life. The World Health Organisation (WHO) defines sexuality as:

... a central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction ...; [it] is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical, religious and spiritual factors. (WHO, 2006, p.5)

On the other hand, sexual health is defined as:

... physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. (WHO, 2006, p.5).

These WHO definitions are used to understand sexuality and sexual health within this thesis. The contribution which sexual health makes to a high quality of life is considerable and a healthy sex life has both physical and psychological benefits (Shepardson & Carey, 2016).

1.3 Sexual function in the menopause

Sexual function is how our body responds to various phases of the sexual response cycle or the outcome of sexual dysfunction (Farlex, 2021). Sexuality is one of the most important parts of a person's identity and the combination of sexual arousal, sexual desire and sexual fantasies actually constitutes sexual function (Farlex, 2021; Nazarpour, Simbar, & Tehrani, 2016). The relationship between sexual response and menopausal status is significantly interdependent (Dennerstein & Lehert, 2004).

Changes in sexual activity and behaviour are frequently seen during the menopause period. During the transition from early to late menopause, sexual dysfunction in women increases from 42% to 88%. There are multiple reasons underlying female sexual dysfunction. Along with the decrease in the oestrogen hormone, dyspareunia occurs as a result of vaginal dryness. Not only hormonally, but also factors such as the stress of everyday life, depression and the relationship between partners play an important role in the changes which occur in the sexual life of the woman. In addition to these, men's sexual problems should also be taken into account. Sexual problems are mainly classified as decreased sexual desire, loss of sexual arousal, problems with orgasm and painful sex or dyspareunia (Collins et al., 2013).

Sexual dysfunction is a prevalent difficulty affecting women's standard of life (Lianjun et al., 2011). It is defined as problems in sexual response or pleasure which cause significant difficulties (Shepardson & Carey, 2016). Sexual dysfunction in women is a problem which has not been adequately addressed (Ambler, Bieber, & Diamond, 2012). Sexual dysfunction in post-menopausal women is a complex problem which is influenced by biological and psychological factors (Graziottin & Leiblum, 2005).

It is estimated that the incidence of sexual dysfunction among all women is between 25% and 63%, but this increases to between 68% and 86.5% in post-menopausal women, which is quite high (Ambler, Bieber, & Diamond, 2012). Sexual satisfaction is not sufficiently defined among post-menopausal women (Mccall-hosenfeld et al., 2008).

Studies have shown that sexual dysfunction such as a decrease in sexual desire is common in post-menopausal women (Yücel & Eroğlu, 2013; Moghassemi, Ziaei, & Haidari, 2011; Nappi & Nijland, 2008; Nobre & Pinto-Gouveia, 2006; Moghassemi,

Ziaei, & Haidari, 2011). Post-menopausal women experience more sexual dysfunction compared with pre-menopausal women (Jarecka & Bielawska-Batorowicz, 2017). It can be a problem in the cycle of sexual response or pain related to sexual intercourse, amongst other problems, according to *DSM-V, Sexual Dysfunctions* (American Psychiatric Association, 2013), (see Table 1.1).

Table 1. 1: DSM-V Sexual Dysfunctions¹

Female dysfunctions	Male dysfunctions	Other dysfunctions
Female sexual interest/arousal disorder	Erectile disorder	Substance/medication-induced sexual dysfunction
Female orgasmic disorder	Male hypoactive sexual desire disorder	Other specified and unspecified sexual dysfunctions
Genito-pelvic pain/penetration disorder	Premature (early) ejaculation	
	Delayed ejaculation	

Source: (American Psychiatric Association, 2013)

For women who have a partner with a sexual dysfunction, this can be a risk factor for low sexual function (Lianjun et al., 2011). In addition, male sexual dysfunction such delayed or premature ejaculation can affect female sexual pleasure and satisfaction (Basson, 2005; Graziottin & Leiblum, 2005). It is therefore important to know about the potential effects of men’s sexual problems on their partners. Women's problems with their partners and relationship dynamics can also contribute to sexual dysfunction in a negative way (Graziottin & Leiblum, 2005). On the other hand, women who were in more frequent sexual communication with their partner were found to have less risk of having low sexual functions (Lianjun et al., 2011). In a study conducted in Kuwait, it was found that the husbands of a significant

¹ Sexual problem, sexual difficulty and sexual dysfunction are terminologies used interchangeably in the literature.

proportion of the post-menopausal women who participated in the study took a new wife. Furthermore, comparing two groups of sexually active women, women with sexual dysfunction were reported to have more problems with their husbands (Omu & Al-Qattan, 1997). These results point to the influence of the male partner on the sexual function of the woman and the importance of the relationship and their culture.

Studies have shown that a woman's age and her partner's age might have an effect on sexual functions (Jonusiene et al., 2013; Ishak, Low, & Othman, 2010; Ferda, Verit, & Billurcu, 2009) and low sexual function was found to have a positive correlation with age (Ferda, Verit, & Billurcu, 2009). For instance, when the post-menopausal women were divided into groups according to their ages, it was observed that the sexual functions of the younger women were better. So sexual dysfunction might increase in direct proportion to increasing age (Jonusiene et al., 2013). In addition to an increase in sexual dysfunction with the increase in a woman's age, one study has shown that the prevalence of sexual dysfunction increased by 4.3 times when the partner's age was over 47 years (Ishak, Low, & Othman, 2010).

DeLamater and Carpenter (2012) developed a biopsychosocial perspective in which biology (health and disease), psychological effects (knowledge, attitude) and relationship characteristics (quality, satisfaction) were found to have an impact on sexual functioning. The biopsychosocial approach provides comprehensive treatment (Berry & Berry, 2013) and is necessary to understand and treat sexual dysfunction in middle-aged women (Thomas & Thurston, 2016). The biopsychosocial model helps to understand the etiology of sexual dysfunction in men and women: "The biopsychosocial model frames the biological, psychological, and social aspects of the patient and her/his health as inextricably correlated" (Berry & Berry, 2013, p.2631).

Studies have shown that women's sexual life at the menopause is affected by not only biological factors but also psychosocial factors (Ghazanfarpour, Khadivzadeh, & Roudsari, 2018; Ussher, Perz, & Parton, 2015; Feltrin & Velho, 2014; Hyde et al., 2011; Hinchliff, Gott, & Ingleton, 2010), for example, the belief that sexual intercourse is reserved for young people and that sexuality is not appropriate for the elderly (Ghazanfarpour, Khadivzadeh, & Roudsari, 2018). Another study showed that anxiety about sexuality occurred as a result of the expectation created by society. In other

words, society regards sexual intercourse as 'healthy' behaviour, whereas sexual apathy can be seen as 'unhealthy' (Hyde et al., 2011). These findings indicate the importance of biopsychosocial factors which will therefore be considered as central within this current thesis.

Studies have shown that there are various factors which affect the sexual function of women during the menopausal period, especially menopausal symptoms. The presence of menopausal symptoms can be seen as one of the main causes of female sexual dysfunction (Jonusiene et al., 2013). For instance, it has been found that women with vasomotor symptoms (VMS) have seriously low sexual functions (Llaneza et al., 2011). The research results related to this subject are discussed in detail in the literature review chapter.

1.4 Gender and ageing, social context and relationships

Gender and sex terms are often used in an interchangeable way by both ordinary people and professionals in science and medicine. When viewed from the perspective of social structure, gender divides the people in a society into two different categories (Lorber & Moore, 2002).

In other words, gender is the name given to the socially constructed characteristics of men and women. Gender can vary from society to society and can also be changed by societies. Gender norms, roles and relationships affect people's attitudes towards health (WHO, 2017). Gender norms are the beliefs about male and female which are historically transmitted from one generation to another. They can vary according to different societies and times and if they are strengthened for any reason, they cause inequality. Gender relations are the social relationships between male and female depending on gender norms and roles. This relationship usually leads to a hierarchy between men and women which leads to inequality (WHO, 2011). Gender functions in a similar way to an organizational process and a social institution in the form of a system. In this system, each level complements and protects the other, and the effects of gender are shown from top to bottom. Gender plays an important role in the transformation of the physical body into the social body. The processes from childhood to menstruation, pregnancy, birth and the menopause in women's life are all actually both biological and social events. Beliefs about femininity and social values influence

women's beliefs about their experiences of menarche, menstruation and the menopause. Menarche is not regarded as happy news in western culture but as the beginning of a situation which reveals the embarrassment of showing blood and the risk of getting pregnant. The menopause was regarded as the beginning of ageing and meant that a woman could no longer bear children. Since the body and reproductive physiology of a western woman are very closely related to her social status, cultural beliefs and attitudes about the menopause also spread to evaluations of femininity (Lorber & Moore, 2002).

Gender is important because women can be affected by traditional gender roles. For example, after entering the menopause some women can feel half man in themselves and have a negative opinion about the menopause because they see it as the loss of the female sense of femininity and of sex interest (Moghasemi et al., 2018; Yang et al., 2016; Ling, Wong & Ho, 2008), and this was probably because of the gender roles expected in society.

1.5 Social expectations

In industrialized countries, the menopause is widely seen as the end of sexual activity for women and women become included in a social category which has lost their femininity and is somewhat different from the normal, whereas in developing countries this is reversed and older women have a say both inside and outside the home. Contrary to the thinking in industrialized countries, there have been studies showing that women in developing countries continue to be sexually active during and after the menopause (Obermeyer, 2000).

Social expectations of older women have a negative effect on sexuality. The reason for this is that societies in many cultures see older women as sexually 'retired' and no longer sexually active. Although it is thought that this attitude has changed over the years, cross-sectional studies have shown that the negative effects of this view continue and that there are still negative sexual changes due to the menopause and menopausal women face the problem of a decrease in sexual desire (Bachmann, 1995). In a Study of Women's Health Across the Nation (SWAN), the findings from 3167 varied racial/ethnic pre- and peri-menopausal women aged between 42 and 52 years reported that the cultural environment and attitudes towards sex had a greater

effect on many features of their sexual function than previous to early menopause. African-American women were found to have sexual intercourse more frequently than other female groups in the study (Avis et al., 2005). Another example is a cross-sectional study conducted with 601 women between the ages of 45 and 60 in twelve different European countries; it was observed that there were significant differences among European countries in terms of women's lifestyle, psychosocial factors and the frequency of sexual intercourse. Women who reported greater prosperity and equality were found to have more sexual intercourse (Dennerstein & Lehert, 2004).

The attitudes of menopausal women towards sexuality may have an impact on the ideals of motherhood and beauty, which form the basis of feminine identity. It was found that sexual problems were really important to women in terms of ideals such as beauty and motherhood (Nappi et al., 2001). In a study conducted with 7243 healthy women between the ages of 40 and 59, it was observed that the negative perception of women's health status had an effect on sexual dysfunction (Blümel et al., 2009). These studies also highlighted the importance of health attitudes on sexual health.

It has been stated that the changing physical conditions and sexual problems after the menopause require older women to be not sexually active and that this both creates and meets a social expectation. Sexual activity in Thailand is seen as an unclean and that is why menopausal/post-menopausal women see themselves as clean (Chirawatkul, Patanasri, & Koochaiyasit, 2002).

1.6 The positive side of the menopause

Studies have shown that the menopause does not just have a negative meaning for women but also has positive aspects (Lindh-Åstrand et al., 2007; Hvas, 2001, 2006; Berterö, 2003; Ballard, Kuh, & Wadsworth, 2001; Avis & McKinlay, 1991). Among the positive expectations of women from the menopause, the most obviously explained is the realisation that there will no longer be menstruation (Berterö, 2003; Ballard, Kuh, & Wadsworth, 2001). In addition, the absence of menstrual bleeding means that women do not experience bursts of emotion such as pain and restlessness due to hormonal changes (Berterö, 2003). Post-menopausal women were found to have a positive attitude towards the end of menstruation (Avis & McKinlay, 1991).

Women have also appreciated the freedom to live life in an unplanned way (Berterö, 2003). A woman in the menopause defines herself as more free. The underlying reason for this was the freedom not to have to look after the children and another reason was the freedom to do something on your own (Hvas, 2006).

Since older women (usually) have grown-up children who are more independent, this was found to make them feel freer. This freedom enables them to go out of the house and enjoy more social opportunities, and for this reason, women's self-esteem increases even more (Ballard, Kuh, & Wadsworth, 2001).

It has been stated that one of the reasons why some women see the menopause positively is that they feel more free in their sexual life and that their sexual life is better (Hvas, 2001). In the idea of sexual freedom, women saw themselves as free about sexual intercourse since they had no risk of becoming pregnant (Berterö, 2003).

The results of a qualitative study with 24 menopausal women conducted in Denmark showed that generally, women mentioned psychological and existential reasons when talking about the positive aspects of the menopause. For example, they saw themselves as a more experienced and competent because of the menopause, felt more independent (factors such as not being obliged to use a birth control method were included in these freedoms), and stood more firmly behind their own thoughts and ideas. It was reported that these positive opinions might be due to age rather than simply the menopause (Hvas, 2006). In another study, Swedish women agreed that the menopause had increased their freedom and that birth control and not having to think about pregnancy had brought them a sense of relief (Lindh-Åstrand et al., 2007). A non-qualitative study showed that the positive aspects of the menopause are the end of the menstrual period and the natural elimination of pre-menstrual syndromes and the risk of pregnancy. Moreover, the participants reported that they could now focus on themselves in terms of their personal growth and individual needs (Hvas, 2001).

In western society, being young and fit is often seen as valuable (Berterö, 2003). Researchers investigating the sociological and cultural aspects of old age and ageing have observed that old age is seen negatively in western society, and that in fact, old age has negative connotations such as being a kind of disability and dependency (Quéniart & Charpentier, 2012). On the other hand, women have positive views about

the menopause by counting only the benefits which are not related to the menopause but which are gained naturally with ageing (Hoga et al., 2015). There are many reasons why women in the menopausal period have a positive attitude towards ageing. For example, women have been found to see themselves as developing individually and gaining new opportunities. They thought that each age had different beauties of its own. An important positive view was that women were happy to take on new roles for themselves, such as being grandmothers (Hvas, 2006). Stereotyping and negative attitudes about elderly women in the community, however, should be perceived as a risk for symptoms (Olofsson & Collins, 2000).

1.7 Factors affecting the experience of the menopause

Every woman's experience of the menopause is different. The menopause is a universal but personal experience. There are many factors which affect the variability of the experience of the menopause. It is a complex process combining psychological, cultural and biological factors (Madden et al., 2010). Research has shown that a large part of people's perception of the menopause is the socio-cultural context (Ray, 2010). In this section, I shall discuss in detail what these factors are.

1.7.1 Sociodemographic and ageing-related factors

Education level (Progetto Menopausa Italia Study, 2005; Gold et al., 2000), alcohol use and body mass index have been found to be associated with menopausal symptoms. Hot flushes and night sweats were found to be more common in less educated women, overweight women and those who do less physical activity. It has also been reported that depression, sleep problems, memory problems and irritability, which affect mental health, are common in women with less education and in those who do less regular physical activity (Progetto Menopausa Italia Study, 2005).

Age, smoking, exercise habits and menopausal status have a significant effect on unbearable hot flushes. A significant relationship was found between the reporting of increased hot flushes and low exercise level, and women who did not suffer from hot flushes were reported to be more likely to have a high exercise level (Guthrie et al., 2005). In addition, full-time work was found to be associated with difficulty sleeping and forgetfulness during the menopause (Gold et al., 2000). It has been observed that

schooling and working reduce depression, anxiety and fatigue, whilst smoking increases both emotional and physical symptoms (Obermeyer, Reher, & Saliba, 2007).

A positive correlation between age and menopausal attitude has been found, with older women reporting more positive attitudes (Papini, Intrieri, & Goodwin, 2002). The effect of the depression of reproductive factors in the menopause has been studied and a study conducted with more than 60,000 post-menopausal women found that the probability of depression which starts after the menopause decreases as the Menars age and reproductive years increase. Moreover, menopausal age was found to be more associated with depression prevalence (Jae, Shin, & Kang, 2015).

A study conducted within western culture showed that women with high levels of education had a more positive attitude towards the menopause and that they reported fewer symptoms (Papini, Intrieri, & Goodwin, 2002). Contrary to the findings of studies stating that as the education level increases, the positive attitude towards the menopause increases, a study conducted in a Middle Eastern country (Bahrain) found the least positive attitude in university graduates and the most positive attitude among women who were illiterate (Jassim & Al-shboul, 2008).

1.7.2 The effect of attitude towards the menopause and psychological factors

Women's attitudes towards the menopause and ageing are significantly related to their well-being being positive. It has also been stated that apart from the biological and psychological effects of the menopause, there is also an effect on well-being from social cultural values in relation to the menopause (Dennerstein, Smith, & Morse, 1994). Attitude towards the menopause has been reported to have an effect on menopausal symptoms, and in particular that women who have negative attitudes, psychological problems such as depression (Bloch, 2002; Avis & McKinlay, 1991) and headache suffered more. Moreover, it has been found that women who have a positive attitude towards their physical appearance experience less problematic symptoms (Bloch, 2002). These results suggest that menopausal symptoms might be associated more with personal characteristics than with the menopause itself (Avis & McKinlay, 1991) .

The attitude towards the menopause actually plays a key role in a woman's experience of the menopause and it is as if living a menopause experience is close to the attitude which a woman displays (Jones et al., 2012). Women with a negative attitude towards the menopause have been found to suffer from more menopausal symptoms during the menopause process (Ayers, Forshaw, & Hunter, 2010). It has been observed that women with a negative attitude towards the menopause suffer more from negative moods, memory problems, joint pain and vaginal dryness problems than those with positive attitudes (Olofsson & Collins, 2000). For instance, in a study of 2572 menopausal periods between the ages of 45 and 55, it was found that women who had negative attitudes towards the menopause generally reported more menopausal symptoms and were more likely to have depression (Avis & McKinlay, 1991). Some of these symptoms, such as depression and headache, affect women's attitude towards the menopause which in turn has a particular effect on some symptoms. Women with a negative attitude towards the menopause were found to have greater difficulty with such symptoms than women with a positive attitude (Bloch, 2002). Few studies have assessed the link between psychological and psychosocial factors and menopausal symptoms. Low emotional intelligence is linked to bad menopausal symptoms. In cases of low levels of stress and psychological problems, the positive attitude of the woman also led to greater use of coping methods (Bauld & Brown, 2009).

It has been reported that menopausal symptoms other than VMS and joint pain have a stronger relationship with psychosocial factors, lifestyle and attitude towards the menopause (Olofsson & Collins, 2000). Many life factors, such as the level of social support a woman received and how stressed she was, had an influence on the VMS during the menopause period (Arnot, Emmott, & Mace, 2021). Moreover, the attitudes and experiences which women have can change their view based on the information which they acquire from their female friends and family members, as well as their mother or an aunt (Berterö, 2003).

1.8 Cultural differences in other countries towards the menopause

Although for practical reasons of time and space it is not possible to discuss in detail all the literature on the menopause here, I shall present a summary of it in this section. In the western world, women's entry into the menopause is not considered to be a good development and is often seen as a negative change. In the literature, it is mostly

medical opinions on symptoms and health loss which are included. The menopause is widely believed to be a deficiency syndrome (Hvas, 2001). In the Arab world, the menopause is referred to as the “desperate age” and is regarded as a development which increases the burden on women because of this change in their lifestyle (Jassim & Al-shboul, 2008).

First Nations women in Ontario did not have a single word to refer to the menopause; it was simply called the time when a woman's bleeding and menstruation stopped. The word ‘menopause’ was coined in 1821 by a French physician and so was not used before then. So in terms of physical and emotional life changes, there was no association with the onset of the menopause as we understand it today. This therefore requires a comprehensive perspective to be taken in regard to women's health care keeping these differences in mind (Madden et al., 2010).

Women around the world have different experiences of the menopause depending on diverse psychological, biological and socio-cultural variables which form their feelings, values and behaviours towards the menopause (Jones et al., 2012). Especially in western society, the menopause is regarded as having a negative impact on women's health and long-term consequences. This point of view reflects the lack of research on the quality of life during and after the menopause (Hoga et al., 2015).

Studies on culture and the menopause have gone through different transitional processes over the years (Melby, Lock, & Kaufert, 2005). Most researchers have supported the view that there is an effect of culture on the menopausal experience (Deeks, 2003). Key studies have shown that there are large differences between cultures on the experience of the menopause (Jones et al., 2012). The wide range of different experiences of the menopause in different countries and the differences in menopausal symptoms can be attributed to cultural expectations, gender roles and women’s socio-economic status at the menopause (Melby, Lock, & Kaufert, 2005).

Comparative international studies have shown that neither biological nor social factors alone are sufficient to explain the differences in menopausal experience among women. Nonetheless, the effect of culture on the menopausal experience is too strong to be underestimated (Jones et al., 2012). A study investigating the frequency of menopausal symptoms in women from four countries (Lebanon, Morocco, Spain and the US) and the effect of the country on the symptoms which they experienced found

that the country factor had a greater effect than other factors. In other words, the biological and socio-demographic characteristics of the country of residence affected the symptoms of menopause (Obermeyer, Reher, & Saliba, 2007). This result clearly shows the importance of the biocultural approach to the menopause.

No supportive evidence has been found that women living in developing countries experience fewer menopausal symptoms than women living in industrialized countries (Obermeyer, 2000). It has been proposed that models should be developed to determine the effect of both biological and cultural factors on the menopausal experience (Melby, Lock, & Kaufert, 2005). The interaction between menopausal symptoms and hormonal changes is unclear, and there is an added influence from social-cultural factors (Obermeyer, 2000).

Several studies have shown that post-menopausal women view the menopause more positively than peri-menopausal women (Morrison et al., 2010; Sievert & Lic, 2003; Papini, Intrieri, & Goodwin, 2002). There is a significant correlation between women with fewer symptoms having a positive attitude towards the menopause (Papini, Intrieri, & Goodwin, 2002). In addition to post-menopausal status, higher education and older age factors have been found to have a positive effect on positive menopausal attitudes (Morrison et al., 2010). A study conducted with 280 women in Bahrain found that women in the post-menopausal period viewed the menopause more positively than women in the pre-menopausal period. Socio-demographic factors, marital status, menopausal status, age and education were observed to be among the factors affecting women's attitudes towards the menopause (Jassim & Alshboul, 2008). A survey of 119 women with menopause aged 45-60 years from Saudi Arabia found that the main symptoms of menopause, such as hot flushes and sweating, were less common than in the west. The most common menopausal symptoms were joint and muscle pain and physical and mental fatigue (Aida, AlMutairy, & AlAteeq, 2015), which might have resulted from cultural and geographical differences as well as age.

The experiences of women in the peri-menopausal and post-menopausal periods can differ because women have physiologically and psychologically different reproductive ability (Dasgupta & Ray, 2017). Whether a woman has a positive or a negative attitude towards the changes which the menopause brings is affected by her personality, family

and socio-cultural status and background (Hoga et al., 2015). Attitudes and perceptions towards the menopause and attitudes towards sexual life can also differ between cultures.

1.8.1 Biocultural perspective

Taking a biocultural perspective on the menopause makes an important contribution to the comprehension of the menopause. At the present time, we know the physiological causes of the menopause and from the medical point of view, the principal focus is on a hormonal condition. However, psychosocial and socio-cultural variables are also of great importance in terms of the course and timing of menopause (Kirchengast, 2004). Technically, although the onset of the menopause is known to begin after the final menstrual period, it is also a cultural phenomenon, and this final period can sometimes be seen as as a mark of hopelessness and sometimes as a new beginning of life. Culture influences the experience of the menopause, how the menopause is perceived and the various symptoms of the menopause. Culture is shared and open to the public; it manifests itself in many areas, for example, in policies for or against birth control, breastfeeding habits, at the time of becoming a mother, and in attitudes to ageing. All these features of culture affect human biology and naturally contribute to the difference and diversity in menopausal experiences (Sievert, 2006). When exploring the menopause, it is necessary to look at it from the biocultural perspective because if the menopause symptoms were only due to a fluctuating hormonal level, the menopause experience would have a far more uniform pattern (Jones et al., 2012).

1.9 Menopause

At birth, a female child has an average of two million eggs and when she reaches puberty, this number drops to approximately 300,000 and the number of eggs continues to decrease gradually over time. By the time she reaches her forties, the response of the few remaining eggs to hormones decreases, but the raising of FSH and LH levels increases the levels of these hormones in an attempt to stimulate the ovaries. This occurs between two and ten years before the menopause. Oestrogen and progesterone production begins to decrease from the ovaries and when the ovaries stop producing these hormones, menstrual bleeding will no longer occur

(Weber, 2007). When a woman starts menstruating, two hormones, FSH (follicle-stimulating hormone) and LH (luteinizing hormone) are produced by the pituitary gland. These hormones initiate the egg release process from the ovaries every month. The ovaries produce oestrogen and progesterone under the influence of these hormones. In total, therefore, all four hormones are involved in the growth and secretion of an egg every month (Weber, 2007).

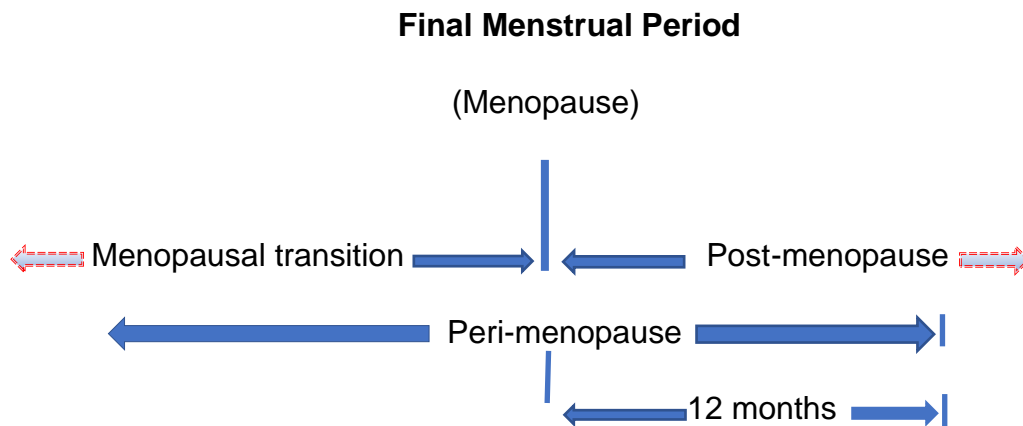
In order to understand the whole process, it will be helpful to start by considering the meaning of the word 'menopause'. It has a Greek construction, combining *meno* which means month and *pause* which means cessation. What this clinically means is that if a woman has not had bleeding or spotting for twelve months, she is in the post-menopausal period (Brayne, 2011). Charles de Gardanne, a French physician, first introduced the term the menopause in 1821, and the menopause at that time was seen as a kind of nervous disorder which occurred with various physical and mental illnesses. In 1857, the first specific book on the menopause, *The Change of Life in Health and Disease*, was written by Edward Tilt in the UK. Tilt identified 135 different symptoms caused by the menopause, and the list included hysterics and uncontrollable irritability. Tilt's book was the first to use the term "life change" (Roush, 2010).

Menopause is a time-period which indicates the end of a woman's reproductive ability and the change in hormones which this entails is swift (Hill, 1996). The menopause is defined as the permanent termination of menstruation caused by loss of ovarian follicular activity (WHO, 1996). It is a gradual process in which women first experience pre-menopause before entering the menopause and then post-menopause (NICE, 2015a).

The term 'pre-menopause' is often used ambiguously, either to refer to the one or two years immediately before the menopause or to refer to the whole of the reproductive period (several decades) prior to the onset of the menopause. The term 'peri-menopause' includes the time immediately prior to the menopause (when the endocrinological, biological and clinical features of approaching the menopause commence) and the first year of the menopause (when menstrual periods have ceased). The term 'post-menopause' refers to the final menstrual period, regardless

of whether the menopause was induced or spontaneous (WHO 1996; pp.12-13) as demonstrated in Figure 1.1 (induced the menopause will be discussed later).

Figure 1. 1: The relationship between the different time periods surrounding the menopause (WHO, 1996).



Some additional information may be required to distinguish between these stages. For example, when a woman is asked when her last menstrual date was and she replies that it was within the last two months, this means the pre-menopausal period. If the answer is between the last three and twelve months, it refers to the peri-menopausal period, and if her answer is longer than twelve months, it is after the menopause, that is, in the post-menopausal period. These stages are explained in Table 1.2 (Sievert, 2006)

Table 1. 2: Menstrual status in the stages of the menopause transition

Stage	Menstrual status
Pre-menopause	Regular cycling: has experienced a menstrual period during the previous two months
Peri-menopause	Irregular cycling, has had a menstrual period from three to eleven months previously
Post-menopause	Had the last menstrual period at least twelve months ago

Source: (Sievert, 2006;p.9)

Surgical or induced menopause is the menopause which occurs after the surgical removal of the ovaries (oophorectomy) (Weber, 2007). In addition to the definitions of

the menopause, the definitions of the menopause transition and climacteric are also important for a full understand of the meaning of the definitions of the menopause. 'Menopause transition' is defined as the period in which changes in the menstrual cycle which occur before the last menstrual period generally increase. 'Climacteric' is the term given to the stage which includes the transition of a woman from a reproductive state to a non-reproductive state (Collins *et al.*, 2013). 'Amenorrhoea' refers to a circumstance when a woman in her reproductive period does not have a consecutive menstrual period for three months or more (Monteleone *et al.*, 2018).

According to the WHO (2018), global life expectancy was 72.0 years for children born in 2016, and 74.2 for females with a range of 61.2 years in the WHO African Region to 77.5 years in the WHO European Region. Women tend to live longer than men and the difference between male and female lifespans in 2016 was 4.4 years globally. According to the Office for National Statistics (ONS) (2018), the average life expectancy at birth in the UK was 82.8 years for women in 2013-2015. The ONS 2011 census recorded that more than eleven million women over 45 years of age lived in the UK and this number is estimated to rise gradually (National Collaborating Centre for Women's and Children's Health, 2015). By 2031, the average life expectancy of women is estimated to reach the age of 85 in the UK. According to this estimate, UK women can anticipate more than 30 years of post-menopausal life (Collins *et al.*, 2013). Thus the ratio of post-menopausal women within the overall population has been increasing due to increased life-expectancy. As women are living longer, they are spending a greater proportion of their lives in the post-menopausal period.

In 1990, it was estimated that there were 467 million post-menopausal women in the world and that the mean age of these women was 60. It was also estimated that the number of women in the post-menopausal period in the world will increase to 1.2 billion by 2030 and will increase by 47 million every year (Hill, 1996). The average age of women to enter the menopause is between 50 and 52 but this age range can vary between the ages of 45 and 55. Smokers are more likely than non-smokers to enter the menopause process as much as two years earlier (Roush, 2010). In the UK population, the average age of women experiencing natural menopause is 51, but there is large variation between women, and 1% of women go through the menopause before the age of 40 (NCC-WCH, 2015). The proportion of women under the age of 30 experiencing the menopause is 0.1% (Brayne, 2011; Rees, 2008a). According to

the North American Menopause Association (2018) the average age of natural menopause is approximately 52, but women can go through the menopause at any time between the ages of 40 and 58 years (NHS, 2015; Sarri, Davies, & Lumsden, 2015). For example, in one study, the mean age at which women began to experience hot flushes was 45.3 years (Williams et al., 2008), whereas another found that hot flushes can continue after peri-menopause and last for an average of 10.2 years (Freeman et al., 2011).

1.10 Menopause symptoms

For a woman, the experience of the menopause is highly personal and hence the prevalence and frequency of menopausal symptoms, particularly VMS, are influenced by personal differences, a person's past experiences, and environmental factors (Monteleone et al., 2018). The menopause transition period usually covers five to ten years. The most subtle early symptoms of peri-menopause actually begin in a woman's thirties, but the first time that women notice them is usually when they are in their forties (Roush, 2010). Most menopausal symptoms can be classified as physical or psychological. Physical symptoms include hot flushes, night sweats, palpitations, headaches, bone and joint pain, asthenia, tiredness, breast tenderness and vaginal irritation, dryness, burning and itching. Psychological symptoms include depression, loss of memory, irritability, poor concentration, tiredness and loss of confidence. Hot flushes and vaginal dryness are the most difficult symptoms for women and these two symptoms are experienced by more than 70% of women because they are associated with the decrease in oestrogen levels (Bruce & Rymer, 2009).

1.10.1 Vasomotor symptoms (VMS)

Types of menopausal symptoms have been reported differently by different studies, with VMS seen as hot flushes, night sweats, cold sweats, palpitations or a combination of these symptoms (NCC-WCH, 2015). VMS mainly include hot flushes and night sweats (Currie, 2013; Rees, 2008b) and are the main physical symptoms of the menopause (Hunter et al., 2012). These symptoms can even appear earlier, before changes in the menstrual cycle, and these early symptoms are the most devastating peri-menopausal symptoms (Rosenfeld, 2004). Scientists believe that hot flushes

occur as a result of abrupt fluctuations in the LH in reaction to decreased oestrogen levels (Weber, 2007)(Rosenfeld, 2004).

In the largest cross-sectional cohort study conducted in the UK, it was found that 90% of the 10,418 post-menopausal participants had experienced hot flushes and night sweats. On the other hand, 54% of women between the ages of 54 and 65 in the post-menopausal period were reported to still have symptoms of hot flushes and night sweats (Hunter et al., 2012). Due to night sweats, conditions such as fatigue and irritability evolve to cause deep sleep problems. Symptoms can occur without stopping the menstrual cycle and usually last for fewer than five years. On the other hand, for some women, this situation can vary and these symptoms can continue for a longer time (Rees, 2008b).

Women describe hot flushes as a sensation of heat which starts in the abdomen or chest and reaches the neck and face (Weber, 2007) and it is often accompanied by sweating (Thurston & Joffe, 2011). Hot flushes are experienced by women in different ways. The most disturbing of these is the condition called night sweats which occur at night and disrupt sleep. The duration of a hot flush can range from a few seconds to a few minutes (Weber, 2007). If hot flushes and night sweats are severe, they can negatively affect the quality of a woman's work, sleep and life (Currie, 2013). A woman's responses to vasomotor symptoms (VMS) vary among individuals; they can be uncomfortable as well as causing insomnia (Rosenfeld, 2004).

1.10.2 Sleep problems

Sleep has been defined as a complex behaviour which is vital for maintaining a healthy life (Landis & Moe, 2004). After menopause, it is sleep quality, in other words efficiency, which deteriorates rather than sleep time. It takes more time to fall asleep after the menopause and less time is spent in restorative deep sleep. Since more time is spent on light sleep than deep sleep, women with menopause are more sensitive to external stimuli and wake up more easily (Roush, 2010).

Sleep problems affect middle-aged women more than at any other time of life as they approach and pass menopause (Shaver & Zenk, 2000). The most common sleep disorders are insomnia, night-time breathing disorders and restless legs syndrome (Guidozzi, 2013). More than one factor can occur in the emergence of this problem

(Guidozzi, 2013; Ameratunga, Goldin, & Hickey, 2012) as well as hormonal changes (Ameratunga, Goldin, & Hickey, 2012). In addition to hot flushes and night sweats, another symptom associated with poor sleep in peri-menopausal and post-menopausal women is anxiety. Although it is possible for hot flushes to cause waking up from sleep, anxiety is more likely to cause difficulty in sleeping (Roush, 2010).

In menopause, each symptom can support and trigger others, and the intensity of some symptoms can also cause other symptoms to appear. For example, in addition to causing deep sleep problems, night sweats can cause fatigue and irritability (Rees, 2008b). Sleep difficulties increase as the menopause progresses and women who experience this symptom can find that it has a negative affect on their normal lives. In the long term, it might also have some consequences on both their mental and their physical health (Baker et al., 2018).

According to the results of a study conducted on a community multi-ethnic basis on the health and menopausal symptoms of 12,603 women between the ages of 40 and 55 in the menopausal period, 38% of them reported sleep disorders. The highest rates were in the surgical post-menopausal period (47.6%) and 45.4% in the peri-menopausal period. In addition, some factors such as ethnic origin, vasomotor and psychological menopause symptoms, self-perceived health perception and level of education have been found to have a significant relationship with sleep difficulty (Kravitz et al., 2003).

1.10.3 Urogenital problems

Menopausal women can experience some symptoms related to the urogenital system arising from the menopause (McVeigh, Guillebaud, & Homburg, 2008). These are listed in Table 1.3.

Table 1. 3: Urogenital symptoms around the menopause

Vaginal Symptoms	Urinary symptoms
Vaginal dryness, irritation, discharge	Recurrent urinary tract infections
Vulvo-vaginal pruritus, pain	Urinary frequency, urgency
Dyspareunia	Dysuria, voiding difficulties
Post-coital bleeding	Urinary incontinence

Prolapse	
Anorgasmia	

Source: (McVeigh, Guillebaud, & Homburg, 2008).

Progesterone and oestrogen receptors are located in the vaginal urethra, bladder and pelvic floor muscles (Collins et al., 2013). Oestrogen and progesterone receptors throughout the urogenital system are sensitive to the hormonal changes which occur during the menopause. This is characterized by changes in all tissues such as epithelial thinning, decreased vascularization, decreased muscle mass and increased fat ratio (Bruce & Rymer, 2009).

The main reason for menopausal women to experience urogenital atrophy is the decreasing oestrogen hormone (Calleja-Agius & Brincat, 2015), and vaginal atrophy and urinary problems occur with oestrogen deficiency. Vaginal atrophy is a common problem during the menopause (Rees, 2008b). Vaginal atrophy affects life negatively and shows many disturbing symptoms such as dyspareunia, interrupted sexuality and vaginal itching, dryness and burning (Collins et al., 2013; Rees, 2008b). Symptoms usually gradually get worse over time even after the menopausal transition has passed (Calleja-Agius & Brincat, 2015).

This problem affects more than 50% of women in the post-menopausal period and these symptoms not only cause discomfort, but can also negatively affect sexual health. Moreover, because women are ashamed to talk about these symptoms, they cannot discuss these issues with their doctors (Milsom & Molander, 1998). A study of 2045 British women aged between 55 and 85+ found that 49% of them had been affected by urogenital symptoms at one time. The study reported that approximately 12% of those who reported dyspareunia and/or vaginal dryness thought that it was a serious problem. About one in ten women admitted that they were embarrassed to talk about vaginal pain, itching and painful sex (Barlow et al., 1997).

1.10.4 Irregular vaginal bleeding and menorrhagia

A normal menstruation period occurs over three to six days and the amount of bleeding is about 80 ml of blood loss. Menstruation lasting for seven days or more and menstrual bleeding of more than 80 ml is called menorrhagia. Abnormal uterine bleeding is estimated to affect between 11% and 13% of the (female) population, but

this increases with age and reaches up to 24% in the 36-40 age group (Marret et al., 2010). With age, there is an increase in the amount of blood lost during menstruation. Irregular vaginal bleeding and menorrhagia are seen as pathophneumonia of the menopause (Bruce & Rymer, 2009). Vaginal bleeding seen in the post-menopausal period is a common clinical issue (Burbos et al., 2010, 2012). Among the most common causes of bleeding are atrophies in the genital area or some benign tumours such as endometrial polyps (Burbos et al., 2012). The incidence of post-menopausal women with bleeding was found to be inversely proportional to the time passed after the menopause. The incidence of bleeding after amenorrhoea in the first twelve months after the menopause was estimated at 409 per thousand women, and it was estimated to decrease to 42 per thousand people more than three years after the menopause (Astrup & Olivarius, 2004). In the UK, women with post-menopausal vaginal bleeding are directed by their GP to a secondary care centre within two weeks of their first application to investigate whether there is any malignant cause (National Health Service (NHS), 2020; Burbos et al., 2010). Changes in the amount and timing of menstrual bleeding are common during the transition to the menopause and the reason for the increase in the amount or duration of menstrual bleeding in the transition to early menopause is often hormonal. On the other hand, as the underlying cause of abnormally heavy bleeding, steroids are not necessarily responsible when given for hormonal reasons, but there may be other causes such as obesity (Van Voorhis et al., 2008). A prospective community-based cohort study of 1320 middle-aged, African-American, Caucasian, Chinese and Japanese women confirmed that there were longer and more severe periods during the menopause transition. It has been reported that menstrual bleeding varies depending on race, ethnicity, body mass index and known uterine fibroids (Paramsothy et al., 2014) .

1.10.5 Weight gain

Most women can gain weight during the menopause. The calorie burning rate is thought to decrease as an effect of the hormonal changes during the menopause process. Because more fat is stored than before, there can also be changes in body shape, most often seen as an increase in the waist area (Currie, 2013).

Weight gain is the main health problem for middle-aged women (Davis et al., 2012). There is a relationship between weight gain and factors such as an increase in blood

pressure, raised cholesterol, low levels of lipoprotein and fasting insulin. For these reasons, weight gain is common in women during the menopause (Wing et al., 1991). The hormonal changes which occur during the peri-menopause period contribute to the formation of obesity in the abdominal region, which causes both physical and psychological morbidity (Davis et al., 2012).

There is a relationship between weight gain and the prevalence and severity of some menopausal symptoms (Thurston et al., 2009; Chedraui *et al.*, 2007). Weight gain has been shown to be among the main risk factors for vasomotor complaints (Li et al., 2003). It has also been determined that there is a relationship between body fat gains and hot flushes (Thurston et al., 2009). With menopause, weight is gained in the abdominal region and abdominal obesity is an important risk factor for many menopausal symptoms such as hot flushes, muscle pain, joint pain and depression (Chedraui et al., 2007).

1.10.6 Other symptoms related to the menopause

Breast tenderness is often a symptom encountered in the early period of the menopause, and the frequency and severity of this symptom decrease with age (Bruce & Rymer, 2009). Sensitivity seen in breasts is usually caused by excess oestrogen. Although most symptoms of the menopause and peri-menopause are due to a decrease in oestrogen levels, fluctuations in oestrogen levels can cause symptoms of oestrogen excess (Currie, 2013). VMS can be linked to symptoms such as headache, palpitations and dizziness (Currie, 2013).

Joint and muscle pain is a common problem in women during the menopause. These symptoms both negatively affect the life quality of a woman and create a burden on the health system (Blümel et al., 2013). For instance, a study conducted with women between the ages of 40 and 60 in Nigeria on the symptoms of the menopause found that the most common menopausal symptom was reported as joint and muscle pain (59.0%) (Olaolorun & Lawoyin, 2009). Furthermore, in a cross-sectional study conducted with healthy women aged 40-59, it was found that the incidence of muscle and joint pain was high (63.0%) and this health problem was associated with menopausal symptoms, especially VMS (Blümel et al., 2013). These and similar

results show the importance of focusing not only on the most common hot flushes symptom in menopausal symptoms, but also to consider other symptoms.

Ageing of the skin is associated with reduced elasticity. Changes in the external appearance caused by wrinkling can cause a decrease in self-esteem (Calleja-Agius & Brincat, 2012). For instance, an epidemiological survey conducted with 3875 women aged 40 and over in the post-menopausal period reported that 36.2% of the participants had dry skin. Another result of that study was that the use of oestrogen was effective in preventing dry skin (Dunn et al., 1997). Since the use of oestrogen after the menopause increases the content of collagen in the skin, it can decrease the problem of ageing dry skin (Calleja-Agius & Brincat, 2012). Oestrogen deficiency can cause osteoporosis, bone fractures, heart health problems and cerebrovascular problems as late effects (Clifford et al., 2012).

1.10.7 Psychological symptoms

During the menopause, psychological symptoms can be seen as well as physical symptoms. These symptoms can increase due to physical symptoms. In this section, general information about the frequently encountered and frequently reported psychological symptoms during the menopause is presented. Psychological symptoms such as mood swings, anxiety, difficulty concentrating and forgetfulness experienced during the menopause can be a direct result of the hormonal changes experienced during the menopause period, or maybe an indirect result, for example, possibly due to insomnia. In addition, external factors arising from work or family life can have an effect on psychological symptoms (Currie, 2013).

It is important to consider the lifestyle, body image and socio-educational factors in predicting the level of depression and anxiety of a menopausal woman (Deeks, 2003). In fact, it has been observed that depression seen in the menopause has more than one cause. For instance, the common cause of the link between menopausal symptoms and depression is the changes in hormones (Vivian-taylor & Hickey, 2014). Some studies have found that there is a relationship between menopausal symptoms and the presence of depressive symptoms (Vivian-taylor & Hickey, 2014; Strauss, 2011). For instance, in a longitudinal eight-year study, a strong relationship was found between hormonal change and the development of depressive moods during the

transition to the menopause in women without a history of depression (Freeman et al., 2006).

In the 1990s, there were studies which concluded that there is no relationship between menopausal status and depressive symptoms (Matthews et al., 1994; Kaufert, Gilbert, & Tate, 1992). For instance, a cohort study conducted with 541 healthy middle-aged pre-menopausal women showed that menopausal status was not related to depressive symptoms (Matthews et al., 1994). Moreover, at the end of a study conducted with 477 women six times over three years, it was reported that it was the changes and stresses in the family life that stimulated depression in the women during the menopausal years rather than the hormonal changes (Kaufert, Gilbert, & Tate, 1992). However, these studies had many methodological limitations (Bromberger et al., 2011).

Cognitive complaints such as forgetfulness, brain fog and difficulty concentrating are common in women during the menopause. Women who experience these symptoms may be unsure whether this problem is related to the menopause or if it is due to another disease, or even simply to ageing (Maki & Henderson, 2016; Schaafsma, Homewood, & Taylor, 2010). For instance, the Study of Women's Health Across the Nation (SWAN), which involved 16,065 multi-racial/ethnic participants aged 40 to 55, reported that 31% of pre-menopausal women, 44% of early peri-menopausal women and 41% of post-menopausal women had experienced forgetfulness (Gold et al., 2000). Mood swings are also one of the symptoms experienced by women in the menopause (Barrett-Connor, Grady, & Stefanick, 2005; Ballard, Kuh, & Wadsworth, 2001).

The reason why memory problems occur during the menopause and then return to normal has not been fully explained. The fact that memory does decrease with advancing age might not explain the fall in the menopause because a woman's post-menopausal memory usually returns to normal, which would not be the case if the reduction in memory capacity is age-related (Maki, 2015). These results show that when looking at menopausal symptoms and evaluating women's health during the menopause from a physiological perspective, the same attention should be paid to cognitive health.

1.11 Menopause and treatment

In this section, the methods used by women to cope with the symptoms of the menopause are described and discussed. These coping methods are generally considered under two headings. The first is hormone replacement therapy (HRT), and the second is non-hormonal therapy which mostly involves vitamins, herbs and supplements which are believed to have healing qualities. There is considerable controversy and different opinions about the benefits and harms of HRT in the literature. Some of these will be discussed briefly in the following section.

1.11.1 Hormone replacement therapy

HRT is the use of oestrogen and progesterone together or only oestrogen by perimenopausal and post-menopausal women (Andolsek, 2004). There are more than 50 different HRT preparations with combinations and application methods. HRT is used systemically as well as vaginally or topically according to the type of symptom. For example, although systemic HRT is preferred for dealing with hot flushes, it can be preferred vaginally for local symptoms such as vaginal dryness (Collins et al., 2013).

In a UK-based study, data were collected from women participating in breast screening. One million women were followed between May 1996 and March 2001. The age range of the women was between 50 and 64 years. The findings showed that half of the women had used HRT for a time (McVeigh, Guillebaud, & Homburg, 2008).

The benefits of HRT include reducing VMS, urogenital symptoms, the risk of osteoporosis and the risk of colorectal cancer (Collins et al., 2013; Rosenfeld, 2004). A randomized controlled trial showed that HRT improved VMS regardless of whether oestrogen or progesterone were administered (Rymer & Morris, 2000). HRT can improve the quality of life of post-menopausal women who have menopausal symptoms. Even so, despite the fact that specific benefits such as those described above are known, some women are nevertheless quite reluctant to use HRT (Dören, 1997). Hope et al. (1998) studied the views of British women on the menopause and HRT and found that 17% of the women participants between the ages of 40 and 65 had used HRT. Based on this finding, it has been assumed that the rate of using HRT in women over 50 years of age with menopause is 17% (NICE, 2015b). In addition,

the application of HRT has been reported to be 85% oral and 15% transdermal (Prescribing and Primary Care team & Centre, 2013).

HRT is regarded as the most powerful treatment for reducing the severity of menopausal symptoms (North American Menopause Society, 2012). Even though its beneficial influence is clear, treatment can also have infrequent but critical adverse effects (Vinogradova et al., 2017). In 2015, NICE published a guide on menopause in which it was stated that many women prefer not to use HRT due to the fear of breast cancer, despite its effect on reducing menopausal symptoms. There is a lack of evidence on this issue and information on the effects of HRT on women in terms of breast cancer is needed at the national level (NICE, 2015c). Over the last 30 years, more than 50 observational studies have examined whether the use of HRT increases the risk of breast cancer, but have failed to draw definite and consistent conclusions (Fiorica, 2020).

Bush et al. (2001) reviewed 45 studies which had examined the relationship between HRT and breast cancer between 1975 and 2000 and noted that the evidence does not support the claim that oestrogen use increases the risk of breast cancer or that combined HRT increases this risk more than oestrogen use alone. However, they considered that because of the evidence from a number of studies in the review, there could be a possibility that the use of HRT for more than fifteen years could lead to a small increase in the risk of breast cancer. However, despite the conflicting research findings, the opinion that HRT increases the risk of breast cancer still persists among clinicians and researchers (Fiorica, 2020).

Breast cancer is the second most common cause of cancer deaths in the UK. Approximately 55,200 cases of breast cancer are reported each year in the UK and approximately 11,400 women die from this cause (Cancer Research UK, 2020). In other words, this means that one of every five women with breast cancer dies directly from it. This statistical information is important in terms of a better understanding of the reason why women fear using HRT during the menopause.

Since the hormonal balance of each woman is different, an holistic approach should be considered when using HRT as a treatment for menopausal symptoms (Laura, 2018). There are several factors that a woman considering using HRT should bear in mind when making a decision, including the age of the woman, the stage of the

menopause, whether she has a history of hysterectomy, whether she has any disease, and whether she has breast cancer or a family history of breast cancer, and every woman is unique in her physiological and familial circumstances (Edelman, 2009) and therefore in her attitude and her anxieties.

1.11.2 Alternative and complementary medicines in the menopause

The US National Center for Complementary and Integrative Health (NCCIH) has grouped complementary and alternative medicines under three main headings. The first comprises various herbs, vitamins, minerals and probiotics, which are all regarded as natural products. The second group contains mind and body practices including yoga and meditation, acupuncture, relaxation exercises and pilates. The third group consists of other complementary health approaches which include traditional healing practices and techniques such as Chinese medicine (National Institutes of Health (U.S.), 2018).

Alternative and complementary medicines are broadly used in the treatment of the menopause, but women tend not to fully share with their healthcare provider the alternative medical methods which they use (Tonob & Melby, 2017). It is known that a large percentage of women seek complementary and alternative medicine to relieve menopausal symptoms (Posadzki et al., 2013; Huntley & Ernst, 2003), which suggests that increasing awareness of alternative and complementary medicines can actually increase the effectiveness of treatment through a 'meaning response' (Tonob & Melby, 2017).

The fact that women do not see the menopause as a medical condition was found to be one of the main reasons for choosing complementary and alternative medicines (Hill-Sakurai, Muller, & Thom, 2008). An important factor in women's decision to use alternative medicines could be because they believe that HRT can have possible side effects, as discussed above (Huntley & Ernst, 2003). For instance, a ten-year prospective cohort study of 3302 women with a multi-racial sample of middle-aged women showed that half of the participants were using alternative medicines (Bair et al., 2002). Another study conducted with women aged 45-54 in northeast Scotland found that herbal medicines were used more commonly for menopausal symptoms than prescription medications (Duffy, Iversen, & Hannaford, 2012).

In the west, two of the most preferred and used herbal remedies for menopausal symptoms are black cohosh and isoflavones (which are produced from red clover or soy) (Tonob & Melby, 2017). Known as a traditional food item in South America, maca grows only in the centre of the Peruvian Andes mountains and is often favoured for enhancing endurance and athletic performance and for its effects in treating anaemia and enhancing fertility and its aphrodisiac properties, as well as being used for hormonal and menstrual irregularities in women. However, it is not clear yet what effect maca has on female hormones (Taylor, 2015). Isoflanes are known as phytoestrogens and are often chosen in place of HRT because of their ability to activate oestrogen (Chen, Lin, & Liu, 2015). Studies have shown that isoflavone use is effective in reducing menopausal symptoms such as hot flushes (Chen, Lin, & Liu, 2015; Taku et al., 2012).

Information on the rate of using alternative and complementary medicine by women in the menopause has often been gathered in studies using questionnaires (Posadzki et al., 2013). Although almost half of the women responding to such studies prefer and use complementary and alternative medicines during the menopause period, there have been hardly any investigations into why women prefer this method for dealing with menopausal symptoms reported in the literature (Hill-Sakurai, Muller, & Thom, 2008). The findings which have been reported show that insufficient qualitative research has been carried out and that more qualitative studies are therefore needed. Studies of alternative and complementary medicines have often focused on menopausal symptoms and there has not been enough emphasis on how and why they are used to deal with sexual changes during the menopause.

Summary of the Background Chapter

This chapter began with a discussion of the socio-cultural aspects of the menopause, continued with an explanation of the biomedical terms and has presented both the socio-cultural and biological perspectives of the menopause, and the biocultural perspective has also been discussed.

In general, the prevalence of biologically and medically relevant the menopause-related sources has been of interest during the current research, but the low numbers of socio-cultural studies and the greater emphasis on menopausal symptoms also

point to the importance of this thesis. It is intended that this thesis will be useful in enabling a clearer understanding of the effects which the menopause has on women's health, sexual life and relationships. Before presenting a review of the relevant literature in the chapter which follows, bringing together a general summary of the literature in this field and presenting it in this chapter constitutes an important infrastructure for the thesis. In the next chapter, the Literature review is presented in order to provide information about the existing studies and to reveal the gaps in the field which this current study is designed to address.

CHAPTER 2: LITERATURE REVIEW

Introduction

This chapter set out the process and outcomes of a literature review of studies of menopausal women, particularly studies focusing on the effect of the menopause on intimate relationships and sexuality. The review helped me to learn about previous relevant research and to identify gaps in the literature. It also contributed to determining my research aim and objectives and what methodology and method should be used. The aim and objectives of the thesis are presented at the end of the chapter.

I shall start by discussing the methods of the literature review and explain the search strategy and the data management process. The key findings obtained from the scoping review are presented in two sections as qualitative studies and quantitative studies. This distinction was needed for the better presentation of the findings from the literature review and the larger number of quantitative studies. Six main themes were established for qualitative studies and five for quantitative studies. Dividing the obtained findings into themes in this way ensured that the similarities and differences were better seen and the analysis was stronger.

I carried out an initial literature review but subsequently updated it. In the first review, I looked for research published between January 2005 and May 2018, but because I continued my study after 2018, I felt that it was important to update the review. I therefore ran exactly the same search in September 2020 to identify whether any further research had been published since the first review. From that second search, I identified six new studies and these have been incorporated into the discussion which follows.

2.1 Scoping reviews and search methods

Research in health sciences provides a wide range of information, including nursing. As the extent of the research grows, it also increases the need for this to be well combined with good evidence (Aromataris & Pearson, 2014). A scoping review was used to determine the extent and nature of the existing literature in this subject area. Scoping reviews are performed to obtain a preliminary assessment of the size and

scope of the existing research literature (Grant & Booth, 2009). They are intended to identify and summarize the relevant literature on a particular topic (Arksey & O'Malley, 2005) and to determine the nature and extent of the research evidence (Grant & Booth, 2009). They are useful in describing the key concepts, theories, evidence or deficiencies in previous research as well as mapping the literature in a comprehensive and systematic way (Halas et al., 2015). Instead of systematic reviews, researchers can use scoping reviews to determine the scope of the body of literature, identify gaps, explain concepts or explore their research conduct (Munn, Peters, et al., 2018). The reasons why I chose to carry out a scoping review were as follows. First, the fact that there are too many medical research studies about the menopause period and that the biomedical view is dominant led me to pay attention to the results presented outside the existing information. Second, the scoping review method enabled me to see the existing lack of information (Munn, Peters, et al., 2018). A scoping review was considered to be an appropriate method since there are not many studies on this specific subject in the literature and those which do exist are mostly quantitative. An additional benefit of a scoping review is the analysis of the findings presented in the existing literature and the critical perspective which can be brought to them. Because of these benefits of the selected method, information was obtained about the aims which I sought to achieve in this thesis.

The main difference between a scoping review and a systematic review is that it has more 'scope' than a systematic review, in other words, there is a broader set of inclusion criteria (Munn, Peters, et al., 2018). Systematic review is considered useful in deciding an appropriate approach for policy makers and funders (Munn, Stern, et al., 2018). In addition, a systematic review seeks answers to specific questions rather than extract a general summary of the literature (Joanna Briggs Institute, 2001). A scoping review is recommended for use in cases where a systematic review is not appropriate, especially in cases which exhibit a complex and heterogeneous structure (Peters et al., 2015). Considering all these factors, it was concluded that a scoping review would be the more appropriate for the current thesis.

Table 2.1 shows that the search was undertaken according to the PICO (Population, Interest, Comparison and Outcome) criteria adopted by the Cochrane Collaboration (O'Connor, Green, & Higgins, 2008). The PICO acronym introduced by Fineout-Overholt and Johnston (2005) is used to develop questions. All elements of PICO do

not have to be used in a search, but population and interest are almost always included and often merged with a number of terms for study.

Table 2. 1: Format

Population (P)	Women
Interest (I)	Menopause after 12-month amenorrhea
Outcome (O)	Impact on sex; relationship; intimacy

Table 2. 2: PIO format

Population	Intervention	Outcome
Women	Menopause after 12-month amenorrhea	Impact on sex; relationship; intimacy
Alternative terms		
Female		Effects
Females		Effect
Woman		Impacts
Lady / Ladies		Sex
Older woman		Intimacy
Menopausal women		Relationship
		Sexual relationship

2.2 Inclusion and Exclusion Criteria

Inclusion and exclusion criteria were applied to help to determine the focus and scope of the review (Aveyard, 2014). The criteria set out in Table 2.3 were taken into account when selecting the studies for review: qualitative, quantitative, random controlled trials (RCT), semi-experimental, case-control, and cohort studies peer reviewed and published in English worldwide between January 2005 and September 2020 were included. The time limit for publication was determined for the literature review because women's views and experiences can be influenced by several factors such as communication networks, social media and changes in health services over the

years. Studies have shown that social networking technologies can have an impact on social and behavioural attitudes. Social networking platforms enable people from various cultures to learn something because they allow them to communicate worldwide (Young et al., 2014). So the results of previous studies prior to 2005 might not reflect the current situation.

Table 2. 3: Inclusion and exclusion criteria

Inclusion Criteria	Exclusion Criteria
Empirical research studies focusing on the menopause, relationship and sex	Studies focused only on medical treatment (such as Hormone Replacement Therapy)
	Literature reviews; non-empirical work; thought pieces; commentaries
Publications written in English	Publications not written in English
Studies published in peer reviewed journals	
Studies published between 2005 and 2020	
Type of studies: qualitative, quantitative, RCT, quasi experimental; case control; cohort studies	

Studies focusing more on the physiological changes of the menopause and the medical perspective are discussed in the background chapter of this thesis rather than in this scoping review. The reason for this was that these articles were more appropriate to be included in the background section as they provide general information on the menopause and enable a better understanding of the subject as a whole. As can be seen in this chapter, the included literature is in terms of biomedical frequency and these studies have focused on the physiological symptoms and medical treatment of the menopause. For this reason, in order to fit the purpose of this thesis, I have taken care to include in this review those studies which lie outside the studies

considered in this framework. I shall explain this in more detail in the section on data management and extraction.

2.3 Literature Search Strategy

A comprehensive literature search using the five major search engines was performed. They were:

1. ASSIA (Applied Social Science Index and Abstracts)
2. CINAHL (the Cumulative Index to Nursing and Allied Health Literature)
3. MEDLINE (Medical Literature Analysis and Retrieval System Online)
4. PsycINFO
5. Web of Science

These are well-known databases which capture the breadth of the international health sciences literature. They also cover various disciplines such as medicine, nursing, psychology and social sciences and I was aware that studies concerning the menopause would be indexed in these databases. In addition to electronic databases, Google scholar, backward chaining (referring to the reference lists of relevant articles) and forward chaining (referring to articles which cited relevant articles) were used to increase the number of results, to identify results not listed in the databases and to ensure that no relevant literature was omitted.

Keywords used in the search were 'menopause', 'Postmenopausal women', 'Relationship', 'sex', 'relationship*', 'intima*', 'menopause and intimacy', 'menopause AND relationship AND sex', 'postmenopausal women AND sex AND relationship*', 'postmenopausal women AND intima*', 'postmenopausal women AND intima* AND relationship*'. Attention was paid to ensure that relevant studies were not missed due to differences in the terminology and between British and American English. Further information about the search strategy is presented in Appendix 2.1.

2.4 Data management and extraction

A total of 3775 studies were retrieved in the first search as indicated in the flow diagram shown as Figure 2.1. The title and abstract of each article were evaluated to decide eligibility. More detailed information was needed to understand the suitability of some

articles, and in such cases the article was read. Following removal of 1320 duplicates, 2455 articles were left. 2412 non-relevant studies were excluded after reading title, abstracts and full texts (see Table 2.4) for the first review of literature published between January 2005 and May 2018. 43 full-text articles were assessed for eligibility and after the 5 full-text articles were excluded for various reasons 38 articles were included in the review. In the second literature review, a total of 741 studies were retrieved as indicated in the flow diagram shown as Figure 2.2 published between June 2018 and September 2020. Following removal of 188 duplicates, 553 articles were left. 521 non-relevant studies were excluded after reading title, abstracts and full texts (see Table 2.4). 32 full-text articles were assessed for eligibility and after the 26 full-text articles were excluded for various reasons 6 articles were included in the review.

I was initially unable to access the full version of some articles but I reached these articles by filling out the necessary forms from the University Library service and by opening a correspondence, and I read the full text and decided which ones to include and which to reject.

Table 2. 4: Inclusion and Exclusion of studies

Studies included	Studies excluded
Natural menopause	Surgical menopause
Women (menopausal women and women)	
No focus on any treatment methods	Treatment such as hormone replacement therapy, oral contraceptives, vitamin D, serum parathyroid hormone and sex therapy techniques
	Focus on specific illnesses such as polycystic ovary syndrome, breast cancer, heart disease, headache, migraine, osteoarthritis, type 2 diabetes, obesity, metabolic syndrome, Alzheimer’s disease and depressive syndrome

Qualitative and quantitative	Experimental studies and those which were testing scales
Women who do not have any illness or addiction	Focus on ill women such as HIV-infected women, colorectal cancer in post-menopausal women, post-menopausal women who drink, depressive women
Studies involving perspective, perception, attitudes, understanding, experiences of menopause, sex, relationships, sexual problems, intimacy, sexual life and activity	

I searched the literature (search dates January 2005 to May 2018) to explore the area and define the research question for the thesis, and to conduct the fieldwork. Because 2 years had elapsed, an update was carried in 2020 (search dates June 2018 to September 2020) to identify if any further studies had been published in the area. Using the same search terms and databases, this additional search identified 6 new studies. These have been added to the description below.

A total of 43 articles were identified (search dates January 2005 to May 2018): 26 quantitative and 17 qualitative. These were read in full. Three quantitative studies were then excluded because they focused on high-risk sexual behaviour in post-menopausal women or were related to ageing anxiety, and two qualitative studies were excluded because they focused on diseases of an overactive bladder (OAB) after hematopoietic stem cell transplantation and experiences in sexual health among women. A total of 32 articles were identified (search dates June 2018- September 2020) and from 32 articles 4 quantitative and 2 qualitative studies were included.

The final number of studies included and reviewed was therefore 44: 27 quantitative and 17 qualitative. I analysed the qualitative and quantitative studies separately because this would enable differences between the studies to be identified and to allow what they add and do not add to our knowledge on the menopause to be seen more clearly. The flowchart of the study selection process is shown in Figures 2.1 and 2.2.

Figure 2. 1: Flow chart of the initial inclusion process for literature published from January 2005 to May 2018

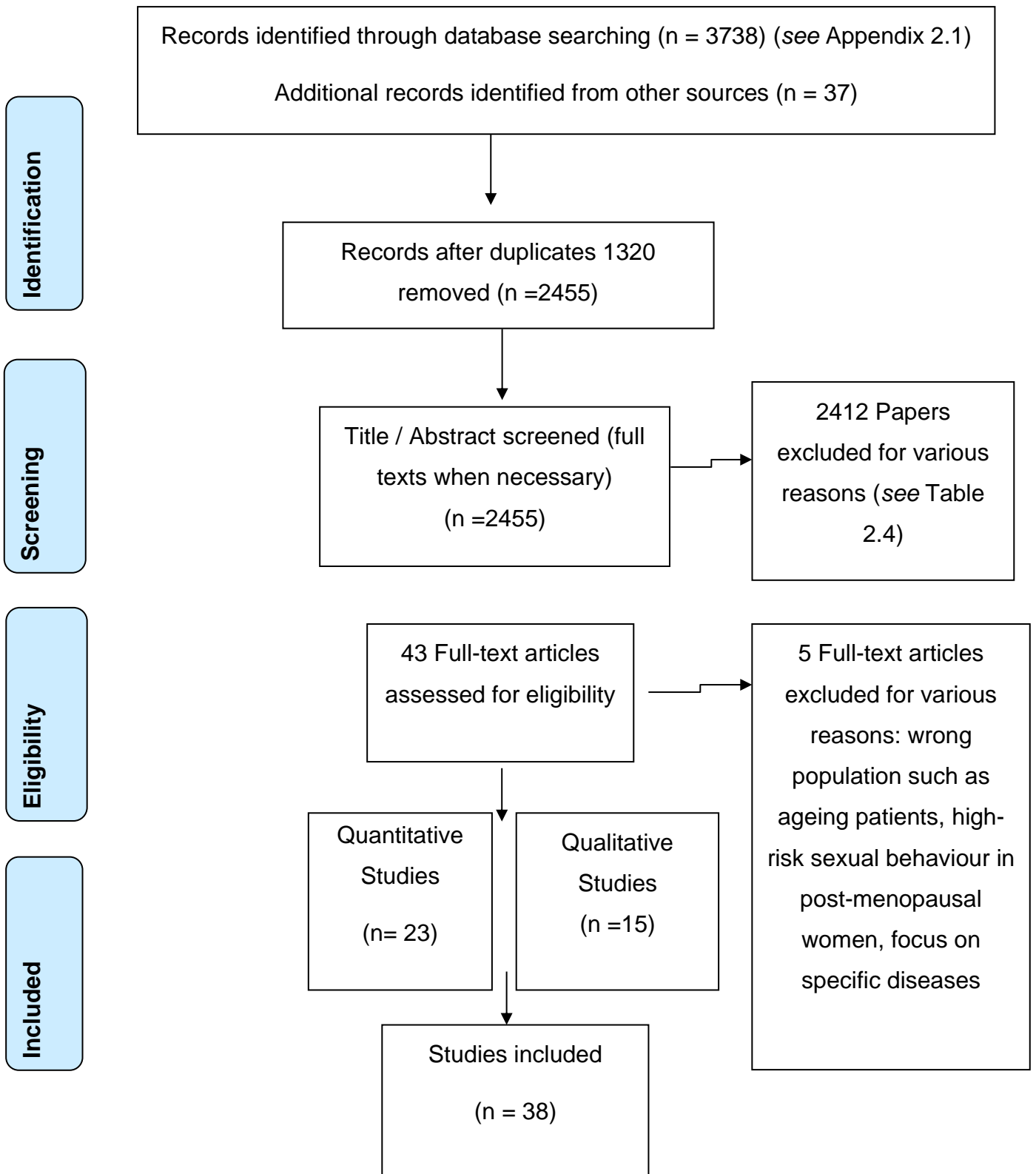
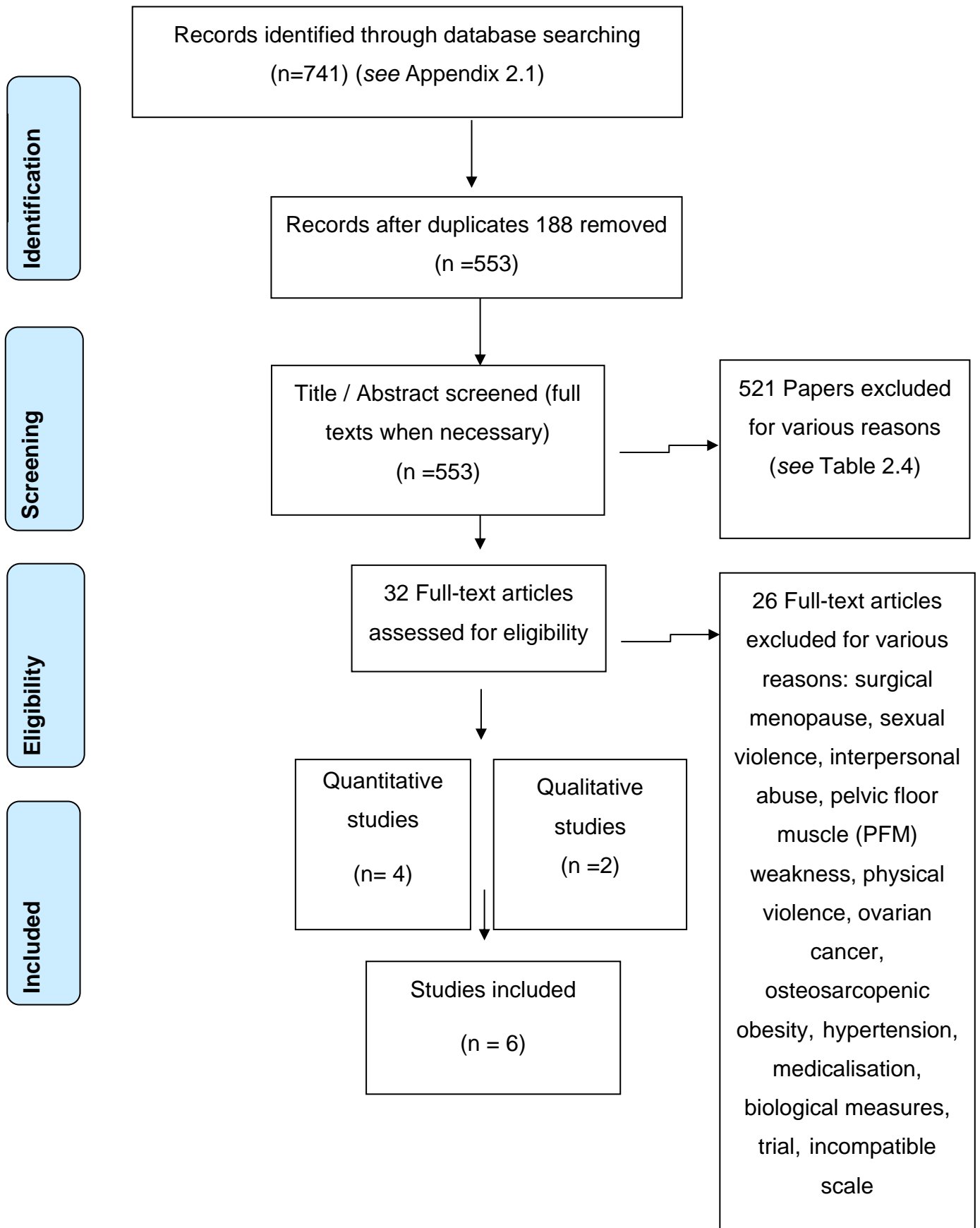


Figure 2. 2: Flow chart of the inclusion process for literature published from June 2018 to September 2020



2.4.1 Literature review reading and analysis processes

I carried out a very careful reading process in order not to miss any relevant articles. I used more than one strategy to do this. First, I manually checked the articles which I had uploaded to Mendeley to see whether they were the same articles which had been duplicated. Then I started to read the articles in order and grouped them into quantitative and qualitative studies. The reason for this was to identify, read and analyse in more detail the few qualitative studies in the literature. I opened a word file and took notes about every article I read, and then I created a table from these notes. As the readings progressed, I started collecting articles based on several factors, such as similar or opposite results, or the participants involved and I grouped them under relevant titles.

For example, I took notes under the heading 'sexual desire' and compiled both qualitative and quantitative articles in this group into separate tables; I also made meaningful interpretations in my head using highlighters and coloured pencils to mark important places. I obtained dozens of such tables and then I printed them out and read them to determine how to put these studies together, group them and analyse them. I later reviewed the articles by going over them one more time from the notes which I had taken. While doing this, I paid particular attention to the findings of each study, its aims, the research method and methodology used, and the participants involved.

I then highlighted in green the studies which I thought were the most relevant and in yellow the ones which I was undecided about and I sent these to my supervisors to get suggestion from them. In line with the feedback which I received from them, I started to re-read the articles which I had previously decided to include in a more detailed way and I enhanced the table which I had created. For example, I had included many details of these studies in this table. Finally, the findings of each selected article were compared in terms of similarities and differences and these were brought together and the writing process was initiated.

2.5 Data analysis

To facilitate examination of the included studies, separate extraction tables for qualitative and quantitative studies were prepared. Relevant information such as the

aims of the study, its design, its country, setting and geographical location, the sampling method, the participants, data collection and data analysis were extracted (see Appendices 2.2, 2.3, 2.4 and 2.5). The findings from the qualitative studies and the quantitative studies were analysed and key themes were identified. These are discussed below: the qualitative studies are discussed first and then I shall move onto the quantitative studies.

2.6 Findings

2.6.1 Description of qualitative studies: setting, population, design

Seventeen qualitative studies were included in this review. These studies had been conducted in ten different countries: Australia (Ussher, Perz, & Parton, 2015), Brazil (Caçapava Rodolpho et al., 2016; Feltrin & Velho, 2014), China (Ling, Wong, & Ho, 2008), Indonesia (Vidayanti & Retnaningsih, 2020), Iran (Moghasemi et al., 2018; Ghazanfarpour, Khadivzadeh, & Roudsari, 2018), the Republic of Ireland (Hyde et al., 2011), Italy (Faccio et al., 2017), Taiwan (Yang et al., 2016), the UK (Bellamy, Gott, & Hinchliff, 2013; Hinchliff, Gott, & Wylie, 2012; Hinchliff, Gott, & Ingleton, 2010; Hinchliff & Gott, 2008) and the US (Thomas et al., 2020; Nosek, Kennedy, & Gudmundsdottir, 2012; Wood, Mansfield, & Koch, 2007). Not all of the studies solely included pre-, peri- or post-menopausal women; some of them also included the perspectives of male participants and healthcare professionals (Ghazanfarpour, Khadivzadeh, & Roudsari, 2018; Faccio et al., 2017; Caçapava Rodolpho et al., 2016). Ten studies involved perimenopausal, post-menopausal and menopausal women, four studies had participants who were women from different age groups. One study was only with men, and had explored men's perceptions, experiences and attitudes toward their wives experiencing natural menopause; one study was with midwives and general practitioners and one study included both women and men as well as health practitioners (gynecologists and psychologists). The data had been collected using a variety of methods; individual interviews, focus groups, semi-structured interviews (face-to-face or telephone) and in-depth interviews. Sample sizes ranged from 12 to 146 participants. Different data analysis methods had been used in the studies, including the phenomenological approach, grounded theory, thematic analysis, content analysis, a Foucauldian discourse analysis ethnographic material, template

analysis, a material-discursive framework, a narrative analysis methodology, Graneheim and Lundman's approach and two unspecified methods (see Appendices 2.2 and 2.3).

Analysis of the qualitative studies resulted in the identification of six main themes:

1. The meaning of the menopause for women and men;
2. Factors affecting women's sexual lives;
3. Changes in sexual desire and orgasm;
4. Talking about sexual issues;
5. Ways to manage menopausal symptoms and improve their sex lives; and
6. Concerns about partner during the menopause.

These themes will be discussed individually in the following sections.

2.6.2 Theme 1: The meaning of the menopause for women and men

Qualitative research has shown that the menopause has both positive and negative meanings for women in studies in different countries; Iran, China, Australia and Taiwan respectively (Moghasemi et al., 2018; Yang et al., 2016; Ussher, Perz, & Parton, 2015; Ling, Wong, & Ho, 2008). For instance, Moghasemi et al. (2018) found that some participants had a positive opinion that there would be no unwanted pregnancies and no need to interrupt sexual intercourse due to menstrual bleeding. In contrast, some participants in that study had a negative opinion because they believed that the menopause causes health problems such as backache and removes the possibility of having children. However, Moghasemi et al. (2018) did not offer an explanation as to why women held positive or negative opinions. Likewise, Ling et al. (2008) also reported that some Chinese post-menopausal women felt relaxed because they did not have to worry about the risk of pregnancy after the menopause. On the contrary, most participants in that study stated that the menopause causes many hormonal and physiological changes and therefore some participants said that after the menopause "I feel like a half a man". These results echo those reported by Yang et al. (2016), who found that Taiwanese peri- and post-menopausal women saw menstruation as a symbol of femininity and stated that they did not feel like women after the menopause;

for them, the menopause was seen as the loss of a sense of femininity and sex interest. Women's self-perceptions are crucial and illustrate the need for research into this issue. Many women in these studies reported an impact on their sense of womanhood after the menopause, which is interesting as these studies were conducted in China and Iran. This tells us something about the gender roles in those countries and the construction of womanhood. For example, it shows us that women's role in those societies is viewed as closely related to fertility. The fact that women lose their reproductive ability because of the menopause might cause them to think that they have lost their role in society.

Other studies made similar findings. Ussher et al. (2015) found that some Australian women perceived the menopause positively because it meant the end of getting pregnant and menses, whereas others saw it negatively since they connected the menopause with increasing age. However, that study had limitations in regard to the participants' differences; for instance, the sample consisted of women who had different kinds of the menopause experience, such as premature menopause caused by cancer treatment, and lesbian women. This mixed sample can be considered a limitation because women's attitudes towards the menopause might be affected by cancer treatment and sexual orientation such as lesbianism. Nevertheless, the authors offered no explanation for the similarities between the participants' opinions: women might have a negative experience if their menopause is premature or medically induced. For instance, since some women in the study had premature menopause after cancer treatment, they thought that the menopause was unexpected and too early and therefore had a sad and negative opinion of it. Also, premature menopause represented feeling old for some women so they had a negative opinion of it. Furthermore, in lesbian relationships, women were able to negotiate different ways of satisfying each other and it was found that they were more likely to report that sexual activities were renegotiated after the vaginal dryness associated with menopause.

Moving on to men's opinions, the findings of a qualitative study carried out in Brazil by Caçapava Rodolpho et al. (2016) to determine the attitudes and experiences of men toward their wives experiencing natural menopause showed that men saw the menopause as a temporary stage of life and as a life problem with both physical and emotional effects and they did not believe that their wives' complaints were so intense. In addition, men reported a decrease in their own sexual desire and reported that they

did not have enough information about the menopause (Caçapava Rodolpho et al., 2016). These results imply that a lack of knowledge about the menopause and men's attitudes and perceptions towards the menopause can create an obstacle to supporting changes in the menopause between couples and to dealing with its negative effects on their relationship and intimacy. Men's views on the menopause are important because they point to the problems that women have with their partner in the menopause process.

2.6.3 Theme 2: Factors affecting women's sexual lives

There are three subthemes within this theme: the effect of menopausal symptoms and health problems, changes in body image, and non-menopausal factors.

2.6.3.1 The effect of menopausal symptoms and health problems

Previous studies have shown that menopausal symptoms such as decreased sexual desire and vaginal dryness have a significant impact on women's sexuality (Ghazanfarpour, Khadivzadeh, & Roudsari, 2018; Yang et al., 2016; Ling et al., 2008; Wood et al., 2007). It has also been shown that significant hormonal and physiological changes in the form of hot flushes, vaginal dryness (Yang et al., 2016; Ghazanfarpour, Khadivzadeh, & Roudsari, 2018; Ling et al., 2008), pain during vaginal penetration and mood changes negatively affect women's willingness to engage in sexual intercourse. A qualitative study conducted in Indonesia found that more than half of the participants reported experiencing negative changes in their sexual relations during the post-menopausal period. Similar to the findings of previous studies, the main reason for this negative effect was decreased libido, vaginal dryness and pain during sexual intercourse due to vaginal discomfort (Vidayanti & Retnaningsih, 2020). In a qualitative study conducted with 35 women, the participants reported that one of the most controversial causes of low libido was vaginal symptoms. Women answered a question about which one of their sexual problems they would prefer to have treated by saying that it would be vaginal dryness (Thomas et al., 2020).

In the US, Wood et al. (2007) reported that symptoms such as severe hot flushes made women nervous and therefore less interested in sex. Additionally, women's

health problems such as vaginal fistula or their partner's health problems such as diabetes, hypertension, cardiac problems and some medications (Ghazanfarpour, Khadivzadeh, & Roudsari, 2018), kidney problems and cardiovascular illnesses (Ling et al., 2008) had negative effects on sexual performance and the regularity of sexual intercourse. For instance, one post-menopausal woman was ashamed because of a vaginal fistula and had concerns about flatulence during intercourse and so avoided sexual encounters (Ghazanfarpour, Khadivzadeh, & Roudsari, 2018). All of these studies, from various countries, tell us that menopausal symptoms and health problems point to the need to consider the effects of the menopause on sexuality.

2.6.3.2 Changes in body image

With the menopausal transition, some women reported experiencing a negative body image, did not feel comfortable being naked in front of their partners and did not want to share a bed with their partners. However, the article which reported this did not explain exactly why women had a negative body images during the menopause (Ghazanfarpour, Khadivzadeh, & Roudsari, 2018). Similarly, Ussher et al. (2015) found that women worried that their partners would not find them attractive after the menopause and that the feared negative reaction to the changes in their body affected their sexual desire and activity level. In addition, a qualitative study conducted in the US by Thomas et al. (2020) reported that the concern of women changing their body image due to age-related or menopausal weight gain reduced their libido which led to them feeling less feminine and less attractive.

On the other hand, some participants (healthcare providers) reported that for men, the quality of the sexual relationship is more important than the body and shape of the partner (Ghazanfarpour, Khadivzadeh, & Roudsari, 2018). However, the data behind this claim were obtained directly from midwives and general practitioners (Ghazanfarpour, Khadivzadeh, & Roudsari, 2018), not from men and women, and it is thought that the results of the study were constrained by the use of secondary data sources. It is important to discuss this directly with women and men in order to increase the reliability of the study results. These results demonstrate that there is a difference in the opinions of women and men regarding a woman's body image. If women know that there is no problem for their partners in regard to their body image, or if they can

talk with their partners about this issue, perhaps these concerns of women might decrease.

2.6.3.3 Non-menopausal factors

Some studies have shown that women's sexual lives are affected not only by menopausal factors but also the experiences of their past and present life and relationships (Ghazanfarpour, Khadivzadeh, & Roudsari, 2018; Feltrin & Velho, 2014; Hyde et al., 2011). For example, in the Republic of Ireland, 25 post-menopausal women in Hyde et al.'s (2011) study linked past and present experiences of relationships, and life stress, especially emotional tragedies such as sexual abuse and children's problems, when they explained their experiences of sexual intercourse and their present sexual relationship. Furthermore, Thomas et al. (2020) found that stress in life also caused a decrease in women's libido and that of a range of life factors, this was generally caused by adult children and grandchildren. It has been suggested that because women have many responsibilities, this causes sex to be abandoned. Feltrin and Velho (2014) suggested that even if sexual problems are related to the menopause, women might also be affected by events which occurred when they were younger.

Furthermore, the quality of a previous marriage and sexual relationship has been found to have a significant impact on the current sexual relationship. Menopausal women could not think of sex because of their responsibilities. For example, the obligations of their daughter's wedding preparations, to look after their grandchildren, and the divorce and separation of their children often had a negative effect (Ghazanfarpour, Khadivzadeh, & Roudsari, 2018). Likewise, in Australia, Ussher et al. (2015) concluded that sexual difficulties or disinterest in sex were related more to psychosocial factors than hormonal factors and Hinchliff et al. (2010) found that women's sexual life at the menopause was affected by not only biological factors but also psychosocial factors. They also stated that personal factors are at the centre of women's experiences related to their sexual history and current partners. These results indicate the importance of the biopsychosocial approach to the menopause.

After qualitative interviews with women aged 50 and over in the UK, Hinchliff et al. (2008) reported that some women viewed their level of sexual desire as a result of their hormonal changes and their response to the desire of a man. They reported that

women also discussed the effect of various factors such as religious beliefs, parental attitudes, past and present relationships, and partnerships in influencing and changing the importance of sexual activity. Bellamy et al. (2012) reported that whereas some women expressed their sexual problems physically, others believed that both physical and psychological factors played a role. Nosek et al. (2012) found that the relationships of women with themselves, partners, work, and family had an impact on the menopause-related problems such as changes in menses, emotional imbalance, vaginal dryness and a lack of sexual desire. The most common cause of low libido among post-menopausal women was reported to be erectile dysfunction in their partners in a qualitative study conducted with 35 women in the US. One of the reasons for this was that the woman did not have enough time to reach orgasm since her partner could not maintain an erection for a long time (Thomas et al., 2020).

These findings imply that the sexual lives of women at midlife and the menopause are influenced by many intersecting factors and are not just the symptoms of the menopause. These results suggest that we need to develop different strategies for understanding and supporting women through the menopause if they experience problems, other than just medical treatment.

Evidence from these studies also shows that women feel a sense of responsibility for sex with their partners and view it as necessary for the relationship (Yang et al., 2016; Ussher, Perz, & Parton, 2015; Hinchliff et al., 2010; Wood et al., 2007). For instance, in qualitative interviews with 18 pre- and post-menopausal women in Taiwan, Yang et al. (2016) reported that some women believed that sex was a necessity for their partner and that the sexual needs of their partners should be met without regard to their own wishes. Similarly, in studies conducted in western societies, some women believed that sex is a woman's obligation and that she therefore has to respond to her partner's sexual needs (Wood et al., 2007; Hinchliff et al., 2010). Furthermore, women continued to engage in sexual intercourse even if they had little desire for it because they thought it was important for their relationship (Ussher, Perz, & Parton, 2015). Hinchliff et al. (2012) reported that women sometimes engaged in sexual intercourse for a variety of reasons, such as anxiety that their partners might seek out another woman, not knowing what else to do, and to satisfy their own sexual pleasures, although they felt unwilling and knew that sexual intercourse would cause pain. Interestingly, the studies also showed that some women feel guilty about their inability

to meet their partners' sexual needs due to menopausal symptoms such as low sexual desire (Yang et al., 2016; Hyde et al., 2011). In addition, two qualitative studies in different countries, in China (Ling et al., 2008) and in the Republic of Ireland (Hyde et al., 2011), showed that women thought that men need more sex than women do. The overall findings show that women see sexual activity as their responsibility despite the studies being conducted in different geographical areas. This suggests therefore that socio-cultural factors and gender roles have a similar impact on women's sexual attitudes and behaviours regardless of their location.

2.6.4 Theme 3: Changes in sexual desire and orgasm

There were mixed findings when it came to sexual desire at the menopause. Studies conducted in China and the Republic of Ireland showed that post-menopausal women experienced reduced sexual desire with the menopause (Ling et al., 2008, Hyde et al., 2011). Hinchliff et al. (2012) reported that women talked about various tactics such as being busy with housework, saying that they were tired, in pain, or going to bed early or late to avoid sexual intercourse due to a lack of sexual desire. Yang et al. (2016) reported that most women in their study (72%) stated that they had a change in their feelings about their sex life after the menopause. However, not all women experienced a decrease in sexual function. For instance, some studies found that sexual desire and the amount of sexual intercourse increased during the menopause. Other studies agreed with this, reporting that libido and orgasm increased in a low number of menopausal women in the UK (Hinchliff, Gott, & Ingleton, 2010) and that whereas many menopausal women had increased sexual desire and pleasure during the menopause, others suffered from sexual issues in Australia (Ussher, Perz, & Parton, 2015).

Clearly, even though only a few studies have focused on women's sex lives after the menopause, the findings were mixed. These findings suggest that there is a diversity with regard to the sexual changes which women can experience at the menopause and this represents a research gap in this area.

2.6.5 Theme 4: Talking about sexual issues

Talking about sexual issues was a key theme, and included talking with healthcare providers and with other people, such as friends.

2.6.5.1 Talking about sexual concerns with healthcare providers

In a study conducted with 22 post-menopausal women in the US, Wood et al. (2007) found that almost all of the participants said that they talked with doctors or other health practitioners only about menopausal issues such as vaginal dryness, vaginal pain or discomfort. Furthermore, when women had told doctors about their sexual concerns, the doctors gave them very little useful information to reduce their problem. Similarly, in a study conducted with 22 post-menopausal women in Southern China, Ling et al. (2008) found that the majority of the participants said that doctors did not ask about their sexual concerns during regular physical check-ups.

In Brazil, a study conducted with 99 menopause outpatients at a Women's Healthcare Centre by Feltrin and Velho (2014) found that some women believed that doctors did not consider issues such as lack of sexual desire as important and that doctors had a viewpoint that the menopause was a disease to be treated and that they saw it as only as a hormonal change. In Iran, Ghazanfarpour et al. (2018) reported that women preferred to seek help about sexual issues from friends, peers or traditional medical practitioners instead of healthcare providers.

These findings suggest that there is no adequate communication between healthcare providers and menopausal women on sexual issues. Also, sexual issues are not sufficiently spoken about, women do not get enough information and do not feel comfortable talking about sexual issues with healthcare providers. More importantly, some doctors can see the menopause solely as a physiological phenomenon even though it is a complex issue with both physiological and psychological implications.

2.6.5.2 Talking about sexual problems with people other than healthcare providers

The studies suggested that most women do not generally talk about sexual difficulties with other people. Two key reasons for this were the topic being taboo (Wood, Mansfield, & Koch, 2007) and the fear of being judged (Ling et al, 2008). Generally,

they did not talk to their female friends (Wood, Mansfield, & Koch, 2007) or partners (Feltrin & Velho, 2014). In fact, however, communication is important for women because one study found that women who were able to talk about sex with their partners were less likely to have sexual desire problems and were more satisfied with their sexual experiences (Wood, Mansfield, & Koch, 2007). Another significant finding was that fear of stigmatization, which was an obstacle for Chinese women to discuss sexuality and not seek medical help (Ling, Wong, & Ho, 2008). That study indicated that social value judgments can potentially interfere with seeking social support and medical advice for sexual matters.

2.6.6 Theme 5: Ways to manage menopausal symptoms and improve their sex lives

Evidence presented in the selected studies shows that women seek various strategies to avoid the physical discomfort of sexual intercourse or the lack of sexual desire (Ghazanfarpour et al., 2018; Moghasemi et al., 2018; Yang et al., 2016). For example, peri- and post-menopausal women developed a range of personal strategies to reduce their problems by taking hormones, watching adult films, communicating and adjusting sexual positions, and increasing exercise (Yang et al., 2016). Women also used different strategies such as faking orgasms, getting help from friends or from traditional medicine, and perhaps because of culture, a few menopausal women who spoke of an emotional and sexual gap with their husbands described visiting charm writers to use magic or similar techniques to bring their husbands closer (Ghazanfarpour, Khadivzadeh, & Roudsari, 2018). Another study in Iran reported that the majority of the women participants took several initiatives included wearing make-up, face massage and even some cosmetic surgery, and liposuction and surgery such as pelvic prolapse repair for cystocele to increase their sexual attraction, and they changed their appearance by these means (Moghasemi et al., 2018). Participants in a more recent study reported that they were looking for a solution by increasing healthy nutrition and physical activity while struggling with the sexual changes which they experienced (Vidayanti & Retnaningsih, 2020).

The results discussed above show only the strategies used by Iranian, Indonesia and Taiwanese women and it can be seen that there is a great lack of knowledge about how women are trying to cope with sexual changes at the menopause.

2.6.7 Theme 6: Concerns about partner during the menopause

The review showed that the majority of Chinese post-menopausal women were concerned that their partners might have extramarital relationships in order to meet unmet sexual needs (Ling, Wong, & Ho, 2008). Likewise, in another qualitative study in Taiwan, Yang et al. (2016) reported that some menopausal women had expressed their guilt and concern that their partners or husbands might prefer to have extramarital affairs. Some Iranian women were also found to be worried that their spouses had a negative attitude towards the menopause because men thought that the menopause and older women are “unsexy and good-for-nothing” (Moghasemi et al., 2018). Conversely, in Iran, Ghazanfarpour et al. (2018) found that women were less concerned about this issue. One of the reasons which they suggested is that in that culture, men are older than women, and therefore women are less likely to be betrayed by their husbands. Some studies suggested that there is an influence of socio-cultural features and gender roles on menopausal women in different countries such as China, Iran and Taiwan.

2.6.8 Summary of the qualitative literature

As this review of the qualitative literature has shown, the menopause can affect women both psychologically and physiologically and studies have indicated that the menopause is unique to every woman and is influenced by many factors. However, the majority of studies on menopause and sex have focused on menopausal physiological effects and attitudes/perceptions. These studies have shown that the menopause can have a significant influence on sexuality and intimacy. I shall now turn to the quantitative studies and discuss their findings.

2.6.9 Description of the quantitative studies: setting, population, design

Twenty-seven of the included studies used quantitative methodologies: three studies were multinational (Chua et al., 2017; Minkin, Reiter, & Maamari, 2015; Nappi et al., 2013b), nine were undertaken in Europe (in one or more countries) (Jarecka & Bielawska-Batorowicz, 2017; Nappi et al., 2016a; Nappi et al., 2016b; Domoney et al., 2013; Nappi et al., 2015; Nappi et al., 2013a; Nappi & Nijland, 2008; Nobre & Pinto-

Gouveia, 2006; Mishra & Kuh, 2006) and fifteen were concluded outside Europe in countries such as South Africa, Nigeria, the US, South Korea and Iran (Dasgupta & Ray, 2017; Guidozi et al., 2017; Bello & Daramola, 2016; Simon et al., 2014; Kingsberg, 2014; Kingsberg et al., 2013; Yücel & Eroğlu, 2013; Moghassemi, Ziaei, & Haidari, 2011; Peeyananjarassri et al., 2008; Birnbaum, Cohen, & Wertheimer, 2007; Taavoni et al., 2005; Golzari et al., 2020; Hong et al., 2019; Parish et al., 2019, Nazarpour et al., 2018). The data for these studies were collected by surveys using online or hard copy questionnaires and measures such as the Female Sexual Function Index. Sample sizes ranged from n=44 to n=8200 participants. The following section briefly outlines the key findings from the quantitative studies.

Analysis of the quantitative studies resulted in the identification of five main themes:

1. Perception and attitudes towards the menopause;
2. Sexual problems;
3. Sexual intercourse;
4. Sexual desire; and
5. Relationships.

2.6.9.1 Perception and attitudes towards the menopause

Three quantitative studies showed that women have different attitudes and opinions towards sexuality around the menopause (Dasgupta & Ray, 2017; Bello & Daramola, 2016; Nappi & Nijland, 2008). Nappi and Nijland (2008) found that women experienced the menopause, mood and sexual changes which could affect their individual lives in a study of 1805 post-menopausal women aged 50-60 years in six European countries. Bello and Daramola (2016) studied 352 pre-menopausal women in Nigeria and found that over half of them (55.7%) were neutral at the beginning of the menopause, whereas 23% had a positive attitude and 21.4% had a negative attitude. Although positive and negative attitudes were almost equal, interestingly, they indicated that young peri-menopausal women had a higher negative attitude toward the menopause. For instance, the negative attitude toward the menopause was 56% in the 41-45 age group, compared with 32.0% in the 51-55 age group. Similarly, a study involving 1400 peri- and post-menopausal women in India found that the post-menopausal

participants had more positive attitudes toward the menopause and ageing than the peri-menopausal women (Dasgupta & Ray, 2017). Taken together, the findings of these two studies show that the peri-menopausal phase might be more difficult for women due to uncertainty about the physiological and symptomatic events which occur during the menopause transition, or to a lack of knowledge resulting in an irregular menstrual cycle (Dasgupta & Ray, 2017).

The results of the two studies showed that among the reasons for the positive attitudes towards the menopause were the end of menstruation and the lack of the risk of becoming pregnant (Bello & Daramola, 2016) and that older women are seen as more valuable in that culture (Dasgupta & Ray, 2017). Negative attitudes were related to feeling incomplete as a woman, assuming the menopause was the beginning of permanent illnesses, feeling too young for the menopause and desiring to have children (Bello & Daramola, 2016), and feeling less attractive after the menopause (Dasgupta & Ray, 2017).

The results of a study examining sexual function and attitudes towards sexuality in 219 healthy post-menopausal women in Thailand conducted by Peeyananjarassri et al. (2008) showed that nearly all of the women expressed a positive attitude towards sexuality in the menopause and that almost all of them (96%) saw having sex in the menopause as normal. In addition, 95% stated that they had sex in order to make their partners happy whilst 77% of them saw sexuality as a way of making themselves happy.

A quantitative study conducted with 258 post-menopausal women in Iran found variables such as sexual knowledge, sexual attitude and religious health care were related to sexual functions. In other words, decreased sexual knowledge, sexual attitude and problems related to religious health were accompanied by sexual dissatisfaction and negative sexual functioning. The results suggested that post-menopausal women should take into consideration that their spiritual and religious behaviour could have an effect on their sexual knowledge and attitudes (Golzari et al., 2020).

In a cross-sectional study conducted with 250 middle-aged, peri-menopausal women in South Korea, it was reported that there was a significant relationship between these factors in terms of the effects of body image, depression and sexual communication

on the relationship between menopausal symptoms and sexual function. The findings showed that sexual function can be improved by reducing depression and improving body image and sexual communication. It was recommended that further studies should be conducted to improve body image and sexual communication and reduce depression in order to increase sexual function (Hong et al., 2019).

These findings indicate that the perception and experience of the menopause seems to be influenced by cultural values and health beliefs (Nappi & Nijland, 2008). Sexuality in general is seen as taboo in women's traditional lifestyle of obedience in Turkey, and thus the menopause is seen as a reduction of sexuality (Yücel & Eroğlu, 2013). In addition, I would like to note that as far as I am aware, there has been no qualitative research on this subject in Turkey.

2.6.9.2 Sexual problems

A number of studies showed that the most common sexual problems are vaginal dryness (Nappi et al., 2016a; Nappi et al., 2016b; Minkin, Reiter, & Maamari, 2015; Domoney et al., 2013; Kingsberg et al., 2013; Yücel & Eroğlu, 2013), dyspareunia (Nappi et al., 2016a; Yücel & Eroğlu, 2013; Kingsberg et al., 2013) and vaginal burns and bleeding (Yücel & Eroğlu, 2013).

According to these findings, vaginal discomfort affects post-menopausal women and their partners negatively both physically and emotionally (Domoney et al., 2013) and their quality of life (Nappi et al., 2013b). For instance, Domoney et al. (2013) found that 69% of women and 76% of men in their sample of 500 men and 500 post-menopausal women thought that vaginal discomfort caused women to avoid physical intimacy. In addition, emotional effects consisted of emotional distance and feeling isolated for both men and women.

Two studies stated that the health service for women offered by healthcare providers was low (Chua et al., 2017; Bello & Daramola, 2016). For example, Bello and Daramola (2016) found that only 4.8% of their women participants had been offered treatment options by healthcare providers. On the other hand, 35.2% stated that they would be interested in treatments offered to them to improve their sexual relationships.

Similarly, in another study conducted in Asian countries, the rate of a genitourinary syndrome of the menopause (GSM) treatment was found to be very low and only about

a quarter of post-menopausal women with GSM had ever used treatment. The urogenital symptoms collectively known as GSM are vaginal dryness and dyspareunia (Chua et al., 2017). Conversely, a study in the US found that the rate of vulvo-vaginal atrophy (VVA) treatment was 73% (Kingsberg et al., 2013) and 68% of for European countries (Nappi et al., 2015). VVA has been regarded as part of GSM under the recommendations of the International Conference on Vulvovaginal Atrophy Terminology Reconciliation Conference to make communication between patients and their healthcare professionals more understandable (Portman & Gass, 2014).

A study conducted with post-menopausal women with GSM symptoms in five Asian countries found that only one in four of them had spoken to healthcare professionals about GSM. Another interesting point is that most of these discussions were initiated by patients rather than by healthcare professionals. The majority of women with GSM said they expected healthcare professionals to start the conversation (Chua et al., 2017). However, studies have shown that the rate of initiating discussions with doctors varies between 11% (Nappi et al., 2016a) and 24% (Chua et al., 2017). In another study, 10.5% of the respondents who reported that they had had an healthcare professional for their gynaecological needs stated that during a routine physical examination, the healthcare professionals usually asked about the participant's sexual activity (Nappi et al., 2016a).

A quantitative study examining the relationship between sexual function and quality of life of 405 post-menopausal women in Iran, 61% of the participants were found to have sexual dysfunction related to desire, arousal, slipperiness, orgasm and satisfaction pain. The statistical results presented in that study showed that women with sexual dysfunction had a significantly lower quality of life. All these results show that sexual function has an undeniable importance on the quality of life. In addition, although these were quantitative studies, the findings actually reveal the need for qualitative studies to examine this issue in more detail and expose the lack of information on this in the literature (Nazarpour, Simbar, Ramezani Tehrani, et al., 2018).

2.6.9.3 Sexual intercourse

The findings from several quantitative studies (Guidozzi et al., 2017; Simon et al., 2014; Nappi et al., 2013a; Yücel & Eroğlu, 2013; Mishra & Kuh, 2006) showed that the rate of sexual intercourse in the menopause declines. For example, a study conducted

in Turkey found that 80% of post-menopausal women had the problem of a decreasing frequency of sexual intercourse and half of them had difficulty enjoying sexual intercourse (Yücel & Eroğlu, 2013). Similarly, Guidozi et al. (2017) found that 52% of post-menopausal women in South Africa had reduced sexual activity and a study conducted in Northern Europe (Denmark, Norway, Finland, Sweden) and Southern Europe (France, Italy) also reported that half of the post-menopausal participants avoided intimacy (Nappi et al., 2013a). According to these results, likely reasons for the reduction of sexual intercourse in women are the desire of some women not to engage in sexual activity after entering the menopause (Yücel & Eroğlu, 2013), vaginal discomfort (Guidozi et al., 2017) and painful sex (Nappi et al., 2013a).

2.6.9.4 Sexual Desire

The included quantitative studies indicated that a high number of post-menopausal women experience a decrease in sexual desire (Yücel & Eroğlu, 2013; Moghassemi, Ziaei, & Haidari, 2011; Nappi & Nijland, 2008, Nobre & Pinto-Gouveia, 2006). For instance, 68% of post-menopausal women suffered from a decrease in sexual desire in Turkey (Yücel & Eroğlu, 2013), and an average of 35% of post-menopausal women experienced a reduced sex drive in six European countries (the UK, France, Germany, Italy, The Netherlands, Switzerland), but participants in the UK reported a higher percentage of sex drive (47%) than those in the other countries (Nappi & Nijland, 2008). The most common sexual dysfunctions in Iranian post-menopausal women was found to be 69.8% loss of sexual desire and 61.7% loss of arousal (Moghassemi, Ziaei, & Haidari, 2011).

Several studies reported that post-menopausal women had more problems in sexual desire (Kingsberg, 2014) and relationships (Jarecka & Bielawska-Batorowicz, 2017) than pre-menopausal women. Kingsberg (2014), for example, found that whereas 27% of pre-menopausal women were dissatisfied with their level of sexual desire level, 34% of post-menopausal women were dissatisfied. The study recognised that post-menopausal women experienced more sexual dysfunction than pre-menopausal women (Jarecka & Bielawska-Batorowicz, 2017). Post-menopausal status is negatively associated with sexual desire, especially in women with low sexual intimacy (Birnbaum, Cohen, & Wertheimer, 2007).

2.6.9.5 Relationships

In a study of both pre-menopausal and post-menopausal women, those in the postmenopausal period were found to have the lowest evaluation of their partner relationship (Jarecka & Bielawska-Batorowicz, 2017). Minkin, Reiter, & Maamari (2015) reported that the prevalence of post-menopausal symptoms significantly influences the relationships of post-menopausal women. Women in the US, the UK and Canada said that the symptoms were worse than the effects on their emotional and physical relationships which they had expected.

There have been studies showing that physiological complaints, often genitourinary problems, can affect sexual life and relationships. These studies note that genitourinary problems are a major negative influence on sexual pleasure and intimacy (Chua et al., 2017, Nappi et al., 2016a) and the rate of sexual activity (Nappi et al., 2016a). A significant body of research has identified that post-menopausal women and their partners can be negatively affected in terms of sex and relationship, both physically and emotionally, by vaginal discomfort (Guidozzi et al., 2017; Nappi et al., 2013a; Domoney et al., 2013). Yücel and Eroğlu (2013) suggested that when women's male partners have sexual activity problems, this can affect women's sexual activity negatively, such as prostate and erectile problems and chronic health problems.

An online survey conducted to explore the perceptions and attitudes of 450 men towards the menopause in the US found that men were aware of their partner's transition to the menopause, but that the symptoms experienced did not correlate with menopause. Men recognized the importance of menopausal symptoms in both themselves and their partners. Less than half of the men surveyed were found to be aware of the treatment options for menopausal symptoms. It was reported that men's attitudes have an impact on decisions regarding symptom management (Parish et al., 2019). These results show that it is important for men to have knowledge about the menopause.

To summarise, the qualitative and quantitative literature on intimate relationships and sexual lives at the menopause show us that women can experience sexual difficulties. The quantitative articles tended to report a high prevalence of problems such as sexual dysfunctions, whereas the qualitative reports showed that the sexual changes

associated with menopause must be viewed in the relevant social and cultural context. These findings suggest that we need to have a better understanding of how women perceive and experience their menopausal changes, how the changes impact on their sexuality and sexual relationships, and how they deal with it.

This current thesis will include post-menopausal women and explore their experiences of the menopause, their and relationships and intimacy, and their coping methods. It will employ both a qualitative research methodology and an IPA methodology because the menopause is widely studied quantitatively but only partly understood qualitatively. As a result, little research about sexual changes and intimacy has been conducted, especially in the post-menopausal period.

This exploration of the theoretical background to the issue and the existing research has shown that a knowledge gap exists in this topic. It is hoped that the findings of this thesis will increase the evidence base and potentially improve future health care by gaining different perspectives on menopausal changes are impacting on their women's sexuality and sexual relationships and how women deal with this. It seems likely that the knowledge generated from this doctoral study will demonstrate not only the physiological complaints affecting menopausal women but also that sexuality is an important issue for these women.

2.6.10 A brief critique of the studies in the literature review

The number of quantitative studies identified in this broad area was remarkably high. Although most of them were excluded for various reasons, I have sought to analyse the results of the 27 most relevant studies, due to their high number and prevalence, have been tried to be analyzed in this chapter, because it is important to present and reflect on the existing relevant literature. However, since in-depth analysis and meaning cannot be presented in quantitative studies, the importance of a qualitative study is obvious. Furthermore, in quantitative studies, since the results are presented in numbers and percentages, there are deficiencies in the interpretation of the results. Quantitative studies have often emphasized the necessity and importance of qualitative studies in this field in their implications and limitations sections. The methodology used in this thesis will therefore help to overcome the lack of qualitative studies in terms of methodology.

Because the distribution of the participants' age groups in some quantitative studies is very wide, the participants' experiences of the menopause are different, their stages are different and any serious diseases which they have are all limitations of the previous studies. For example, the symptoms of the menopause and the problems experienced by a woman in the early period of the menopause may differ from those of a woman who is old and has long years of the menopause. Results can be too far from each other for these reasons and might cause the obtained from their analysis and comparison to turn out in the wrong direction.

In some of the quantitative studies, it was stated that the sample group was hospital-based. This means that the participants could not fully represent the general menopausal population. For example, in a quantitative study of 219 post-menopausal women to examine sexual function and attitudes towards sexuality, all of the participants were women who had applied to the gynecology clinic of a tertiary hospital after receiving referrals from other hospitals (Peeyananjarassri et al., 2008). Likewise, in a quantitative study conducted in Iran, there were some limitations in the selection of samples: participants were selected from a private gynaecology clinic and it was stated in the study that the participants were rich and well educated (Taavoni et al., 2005) .

Peeyananjarassri et al. (2008) found in a study of post-menopausal women that almost all of the women had sex because it made their partners happy. If this study had included qualitative data, the researchers might have been able to determine why almost all of the women thought this way. They also found that there were a few women who said that they avoided sexual intercourse because they were embarrassed by the changes in their body image. Similarly, if qualitative data had been included, it could be better understood why these women were ashamed. In another example, the reason for this avoidance was not specified in a quantitative study showing that vaginal dryness caused both male and female participants to avoid intimacy (Domoney et al., 2013). For example, if the woman experiences pain during sexual intercourse, this can keep her away from sexual intercourse. At this point, a quantitative study cannot answer these questions.

In the some of the qualitative studies, it can also be said that there were limitations in terms of the samples. For example, in a study conducted to examine how the

menopause affects the sexual behaviour of Taiwanese women, it was seen that the participants were women who had applied for an examination for the menopause symptoms in the gynaecology department of a large city medical centre (Yang et al., 2016). This situation can be said to be deficient in reflecting the general population of women in that society as it consisted entirely of women who had sought medical help. The authors of that study were aware of this and suggested that similar studies should be carried out among women who had not applied for medical help.

In another qualitative study, the participants were women who had already participated in another study organized by the School of Public Health (Ling, Wong, & Ho, 2008). The fact that this sample consisted of participants involved in a research study for the second time might have made them more open to talk about sexual matters, or it might also have caused them to hide themselves because they were participating in a second study, and that might have caused them to think beforehand about which questions they would be asked and how they would react to them. As stated in the results of that study, it was found that the participants were very open to talking about sexual issues. However, this may not be the case at all times, because talking about sexual matters is still seen as a sensitive and not open topic in some societies.

Similarly, in another qualitative study of the sexuality of post-menopausal women, the participants were women from a research group called TREMIN (Wood, Mansfield, & Koch, 2007). It has been reported that women registered in TREMIN have more awareness of their health and sexuality than many women as they were informed by researchers working in this system about their health and sexual information. All of these factors suggest that it is inevitable that it will affect the results of the study, as the researchers would have had more information about the health and sexuality of the participants.

As in the quantitative studies, since the age range of the participants included in some of the qualitative studies was also very wide, it created difficulties in determining which data belong to which age group. As discussed in the background chapter and this literature review, there have been studies showing that attitudes depending on women's age and the menopause stage might differ from each other. For example, Feltrin and Velho (2014) reported that the youngest participant was 35 years old and the oldest was 82. This suggests that the results obtained depending on the width of

the sample could be changed in different ways in the results of the study due to the factors of age.

Another criticism of the sample groups in the selected studies is that the participants were very homogeneous in some studies. For example, in a qualitative study conducted with twelve post-menopausal women, all of the participants had been married for more than ten years (Vidayanti & Retnaningsih, 2020). This meant that no data were obtained on the experiences of menopausal women who were not married, had had no sexual intercourse, had had more than one sexual partner or had a different sexual orientation during the menopause period. In another qualitative study, the 22 post-menopausal women participants were white, middle-class and highly educated (Wood, Mansfield, & Koch, 2007). The fact that all of the women were higher-class and educated will also have an impact on the outcomes and will not provide information about lower-class and low-educated women.

2.7 Aim and objectives

As has been made clear in this literature review, there is a dearth of previous research on women's sexual well-being at the menopause which has considered interpersonal relationships and the interaction of biological, psychological and social factors. The aim of this thesis therefore is to explore post-menopausal women's experiences of the menopause and the perceived impact which the menopause can have on their interpersonal relationships and intimacy, and the coping methods which they used.

Objectives

1. To identify women's prior knowledge of the menopause and sources of knowledge through in-depth interviews with any woman who identifies as being in the post-menopause (in other words, that their last menstrual period was 12-24 months ago).
2. To understand relationship challenges at the menopause, again through in-depth interviews.
3. To outline women's understandings and perspectives about the menopause and sexual changes and the coping methods used to manage these sexual changes.

4. To develop recommendations for professional health practice based on these findings.

To explore the aim and objectives set out above and to identify relevant concepts in the literature, a literature review was carried out. This review enabled me to evaluate the quality of the reported evidence and to identify gaps in the literature. The process is described next.

In line with my two literature reviews and my readings on potential methodologies, using a qualitative study method to achieve my research purpose and goals was found to be the study design which would bring me closer to the results which I wanted to achieve in my thesis. I wanted to highlight the feelings and thoughts of the participants by using the IPA methodology. In this regard, I used the IPA methodology devised by Smith et al. (2009) to explore the experiences of women.

I decided to limit the study to women in the early menopausal period because if I were to include all pre-, peri- and post-menopausal women, there would be too wide an age range. This study will therefore focus on women in the early post-menopausal period because that is when the changes which women experience are likely to be most directly attributable to the menopause itself and the physical and psychological changes associated with the process of transition. This thesis will nevertheless include women up to the age of 70 in order to ensure the inclusion of women who go through the menopause later than normal.

CHAPTER 3: METHODOLOGY

Introduction

This qualitative thesis employs interpretative phenomenological analysis (IPA) to address the research aim and objectives. The purpose of this chapter is to provide an overview of the IPA methodology and explain the rationale for choosing to use this approach. I shall first present information on the qualitative paradigms, ontological and epistemological, and their related methodological components. Following this, I shall describe the phenomenological approach.

In the final part of the chapter, I shall provide detailed information about the background and the basic theoretical foundations of IPA, including phenomenology, hermeneutics and idiography, and then I shall explain why IPA was chosen over other potential methodologies.

3.1 The qualitative paradigm

Any research or inquiry is led by a range of beliefs. This range of beliefs or worldview is understood as a 'paradigm' (Killam, 2013). A paradigm is a philosophical model based on a specific ontology, epistemology and worldview, and a system of beliefs widely accepted by philosophers of science (Holloway & Wheeler, 2010; Holloway, 1997; Kuhn, 1970). The word paradigm originates from the Ancient Greek *paradeigma* meaning 'pattern' (Killam, 2013), and is defined as "a theory or set of ideas about how something should be done, made or thought about" (Killam, 2013, p. 5).

The paradigm is similar to the lens in a pair of glasses. For example, when we wear red glasses, everything appears red to our eyes. We see the world in pink when we wear pink glasses. In other words, depending on the colour of the lens which we wear, everything around us changes accordingly. The lens we choose as a researcher, in other words the paradigm, affects the way in which we see the world change in that direction. It affects a lot of what we see and do as a researcher (Killam, 2013).

Qualitative research is a form of social research which focuses on people's experiences and how they interpret and understand the world in which they live. Hence, qualitative research methods are suitable for exploring the individual's experiences and perspectives (Holloway & Wheeler, 2010; Holloway, 1997).

Quantitative measurements and statistical analyses may not be sensitive to the interactions between people, differences between genders, or social, economic and individual differences, so qualitative research is the preferred approach for exploring these issues (Creswell, 2013).

3.1.1 Ontology

Ontology is interested in what the nature of reality is and what its characteristics are (Creswell, 2013; Willig, 2013). "Different researchers embrace different facts" (Creswell, 2013, p. 20), such as the individuals studied and the readers of a qualitative study. When working with individuals, qualitative researchers carry out a study to reveal these multiple facts (Creswell, 2013). The question which drives ontology is 'What is there to know?' Ontological positions can be defined as 'realist' and 'relativist' (Willig, 2013, p. 61).

In research, ontology shows the "researcher's beliefs about the nature of reality". It refers to the study of our being and reality, or the fundamental nature of being, using philosophical terms. Beliefs about what is real and what is true are effective in determining what can be known about reality. Ontological questions include 'What exists?' 'What is true?' and 'How can we sort the existing things?' (Killam, 2013, p. 7).

Instances of ontological positions are those found in the 'objectivist' and 'constructivist' perspectives. Objectivism is "an ontological position that asserts that social phenomena (Bryman, 2012, p. 32; Grix, 2002, p. 177) and their meanings have an existence independent of social actors" (Grix, 2002, p. 177). It means that social phenomena and the categories which we use in daily discourse have a separate existence independent of actors (Bryman, 2012).

On the other hand, 'constructivism' (also referred to as 'constructionism') (Bryman, 2012) is "an alternative ontological position that asserts that social phenomena and their meanings are continually being accomplished by social actors" (Grix, 2002, p. 177). It suggests that social phenomena and categories are not only created through social interaction but are also in a state of constant revision (Bryman, 2012). Briefly, if ontology is about 'what we know', epistemology is about 'how we know what we know' (Grix, 2002, p. 177).

3.1.2 Epistemology

Epistemology is one of the main branches of philosophy. It is particularly interested in “the possible ways of gaining knowledge of social reality”. Epistemology centres on the information-picking process; it provides the answer to the question ‘What and how can we know about it?’ (Willig, 2013, p. 61; Grix, 2002, p. 177). Like many terms used in philosophy, the word epistemology is of Ancient Greek origin, comprising the noun *episteme*, which means ‘knowledge’ (Killam, 2013; Grix, 2002) and the verb *epistamai*, which means ‘to understand’ or ‘to know’ (Killam, 2013); the word *logos* has many meanings, including ‘thought’ and ‘reason’ (Grix, 2002, p. 177).

There are two opposite perspectives in the epistemological position, ‘positivism’ and ‘interpretivism’. (Grix, 2002). In general, positivism is an epistemological position which advocates the application of the natural sciences to studies of social reality (Bryman, 2012; Grix, 2002). Bryman (2012, p. 28) stated that positivism includes some of the following principles:

- knowledge validated by the senses can be guaranteed to be true knowledge (the principle of ‘phenomenalism’);
- the purpose of the theory is to provide testable hypotheses (the principle of ‘deductivism’);
- knowledge is accessed by bringing together facts (the principle of ‘inductivism’); and
- science must be directed objectively.

Interpretivism is a term given to an epistemology which opposes positivism (Bryman, 2012). Bryman (2012, p. 30) explained that

It is predicated upon the view that a strategy is required that respects the differences between people and the objects of the natural sciences and therefore requires the social scientist to grasp the subjective meaning of social action.

The aim of the epistemological approach is to reveal a participant's experiences as closely as possible. On the other hand, it is important to accept the interaction of both the researcher and the participant in that particular context. The content of the thesis includes the participants' own thoughts, beliefs and experiences. My epistemological

position here is how we make sense of what we see together with the experiences which we have. This means that the experiences which women have actually shared are transferred to you through my own lens. For this reason, I have provided detailed information about myself in the Preface section.

3.1.2.1 IPA's epistemological assumptions

IPA has an interpretive phenomenological epistemology. It is concerned with understanding people's relationship with the world and with what is important to them through the meanings which they make. IPA therefore follows some of the following assumptions (Larkin & Thompson, 2012):

- understanding the world needs an understanding of experience;
- IPA researchers dive into a linguistic, relational, cultural and physical world and uncover and engage with other people's personal accounts;
- an idiographic approach is therefore required to make it easier to focus on a particular subject in detail; and
- before being able to engage with other people's experiences, researchers have to define and reflect their own experiences and assumptions.

Both epistemology and methodology are guided by our ontological beliefs. It is sometimes difficult to understand the difference between epistemology and methodology, but it may be useful to know that epistemology is more philosophical than methodology (Killam, 2013).

3.1.3 Methodology

Methodology refers to the path which researchers use in order to systematically explore information. A methodology is more specific than epistemology. The researcher's ontological and epistemological beliefs drive the methodology (Killam, 2013). The methodology of qualitative research procedures is inductive; it differs according to the experience of the researcher in collecting and analysing data. The logic followed by a qualitative researcher is an inductive approach from the ground up (Creswell, 2013). The question which is asked by a methodology is 'How can we go about acquiring that knowledge?' (Grix, 2002, p. 180).

It is useful for researchers to see the distinctions between quantitative and qualitative research. Quantitative research requires a deductive approach to data collection and analysis. In particular it combines the practices and norms of positivism. It embodies the view of social reality as an objective reality (Bryman, 2012). In health-related studies, quantitative methods do not aim to bring healthcare professionals to the centre of people's lived experience. They focus more on numerical points such as treatment outcomes and survival proportions (Biggerstaff & Thompson, 2008).

Conversely, qualitative research follows a research strategy which generally emphasizes words rather than statistics and percentages in the process of data collection and analysis. In general, the relationship between theory and research includes an inductive approach in which the emphasis is on the generation of theories. It rejects positivist practices and norms and prefers to focus instead on how individuals interpret their own social worlds (Bryman, 2012).

Bryman's (2012; p. 36) summary of the main differences between quantitative and qualitative research strategies is shown as Table 3.1.

Table 3. 1: Key differences between qualitative and quantitative research

	Qualitative	Quantitative
The role of theory	Inductive	Deductive
Epistemological	Interpretivism	Positivism
Ontological	Constructionism	Objectivism

Source: (Bryman, 2012, p. 36)

Qualitative researchers construct their data by proceeding inductively, arranging their patterns, categories and themes using the bottom-up approach more abstractly. Throughout the inductive process, researchers work back and forth between datasets and themes until they form a final set of themes (Creswell, 2013). Qualitative methods are more pliable than quantitative methods in ensuring that the voices of the participants are heard more clearly. In qualitative analysis, words take the place of numbers (Grove, Burns, & Gray, 2012). Creswell's (2013, p. 20) summary of ontology, epistemology, axiology and methodology is presented as Table 3.2.

Table 3. 2: A summary of the meanings of ontology, epistemology, axiology and methodology

Ontology	the nature of reality
Epistemology	what counts as knowledge and how knowledge claims are justified
Axiology	the role of values in research
Methodology	the process of research

Source: (Creswell, 2013, p. 20)

3.1.4 Justification for employing the qualitative paradigm

A qualitative approach was adopted for this thesis for several reasons. First, there is a lack of adequate qualitative research on this issue in the literature. Most of the previous research into this issue has been quantitative and has focused on medical aspects of the menopause and their impact on sexual function, as was discussed at length in the literature review (Chapter 2). Additionally, quantitative research does not enable us to understand women's sexuality and the problems experienced by women in any depth (Winterich, 2003). Consequently, qualitative research was regarded as appropriate for this thesis because sexual issues are based on specific cultures and socio-cultural contexts which need to be explored fully (Ghazanfarpour, Khadivzadeh, & Roudsari, 2018). In-depth interviews can help participants to talk freely about their experiences by providing them with an opportunity to reflect. Suggestions have been made that more qualitative research should be conducted to investigate issues related to this topic (Yücel & Eroğlu, 2013) and thus build a more useful evidence base in this area. I shall discuss interviews in more depth and provide more information about data collection in the Methods chapter.

This thesis explores a sensitive topic and qualitative methods enable women to express themselves through communication. The qualitative methodology has an holistic approach and the participants have an opportunity to speak fully in their own words and language about a particular phenomenon (Parahoo, 2006). Furthermore, it is rarely appropriate to develop a questionnaire on such a sensitive topic because some of the words used might have a different meaning for each participant or the meaning of some words may not be known. Each woman's social and cultural habits can be different and this can affect their understanding of survey questions. In addition,

a face-to-face interview gives the researcher the opportunity to observe participants' body language and for participants to ask the researcher about the words which they do not know. In the following section, I shall explain phenomenological approach as the thesis uses an IPA methodology.

3.2 The phenomenological approach

Phenomenological research methods originated in Germany and have a long philosophical tradition (Chesnay, 2014). It is known that the phenomenological approach had its origins in the work of the philosopher Edmund Husserl (1859-1938) (Rodriguez & Smith, 2018; Wertz, 2011). Husserl devised a research method which he called phenomenology for application in philosophy and human sciences. It is known as a descriptive, qualitative study of personal experiences for psychological purposes (Wertz, 2011).

Phenomenology focuses on what is experienced and how it is experienced, rather than on theories and hypotheses which refer to facts about biology or the environment (Wertz, 2011). Phenomenology is regarded as "as a way of thinking about human experience". To put it another way, phenomenology generally deals with the contexts defined by humans and the world as experienced at particular times rather than using abstract expressions about the nature of the world (Willig, 2013, p. 50). A phenomenological study defines the common meaning of several subjects' lived experiences of a concept or phenomenon (Creswell, 2013).

Phenomenology is seen as the philosophical study of the 'being' of existence and experience. It is known that there were two major historical periods of phenomenology, the hermeneutic or existential and the transcendental (Larkin & Thompson, 2012, p. 102). The philosophy of phenomenology is within the naturalist paradigm. Some questions of phenomenological research are 'What is this experience like?', 'What does this experience mean?' and 'How does the lived world present itself to the participant or to me as the researcher?' (Rodriguez & Smith, 2018, p. 1).

Phenomenology is considered a philosophical approach (Eatough & Smith, 2006) and was not originally a method of research (Holloway & Wheeler, 2010). It is the study of the human experience and the ways in which it is presented to us (Sokolowski, 2000). As a research method, it is a means of learning people's life experiences

(Holloway, 1997). Phenomenological studies focus on how people perceive events and how they talk about them rather than on a previously defined categorical and conceptual set of criteria (Pietkiewicz & Smith, 2012). Phenomenology as a philosophy began with Husserl but now provides the basis for its use in modern times as a research methodology (Holloway & Wheeler, 2010).

Husserl and Martin Heidegger were academic colleagues of different generations who frequently taught at the same university. Heidegger became department chair in Freiburg in 1928, replacing Husserl. Husserl believed that Heidegger would continue the philosophical work which he had started, but although Heidegger studied Husserl's work at the beginning, he subsequently proceeded in a very different direction from Husserl's (Chesnay, 2014). Based on the divergent views of Husserl and Heidegger, different approaches and applications have been developed for phenomenological research (Rodriguez & Smith, 2018).

The phenomenological approach has become widespread in the field of health sciences. It covers many subject areas including the patient experience and the relationship between chronic illness and health services. Although there are different types of phenomenology as a research approach, all of them have similar aims but different ways of understanding epistemology and ontology (Holloway & Wheeler, 2010). Descriptive phenomenology (Husserl) was called transcendental phenomenology and interpretative phenomenology (Heidegger) was also called hermeneutic phenomenology (Rodriguez & Smith, 2018). The descriptive and interpretive approaches differ in the details. For example, researchers who adopt a hermeneutic approach attempt to interpret the meaning of a phenomenon in context whereas descriptive phenomenological researchers identify and define basic and universal structures. Interpretative phenomenology is the intersection of the ideas of researchers and participants, both of whom are understood to have individual perspectives on particular phenomena, but because they live in a common world they also have shared perceptions (Holloway & Wheeler, 2010).

The interpretative approach enables researchers to reach a deep understanding of the lived experience. It is used specifically to examine the contextual characteristics of experience in relation to other influences such as culture and gender (Matua & Van Der Wal, 2015). IPA was the qualitative methodology chosen for this thesis. In the

following sections, I shall provide a brief history and origins of this particular methodology and explain why other methodological were considered but rejected.

Rodriquez and Smith (2018, p.1) listed the main differences between descriptive phenomenology and interpretative phenomenology and these are shown as Table 3.3.

Table 3. 3: Key differences between descriptive phenomenology and interpretative phenomenology

Interpretative phenomenology	Descriptive phenomenology
Orientation is ontological, questioning experiences and understanding: such as ‘What does it mean to be the person in this context, with these needs?’	Orientation is epistemological and its question is ‘How do we know what we know?’
Meaning is effected by the researcher's belief system	Meaning is not effected by the experience or beliefs of the researcher
The interpretation clarifies what is already known	Although data stand alone, their meanings can be reestablished

Source: (Rodriguez & Smith, 2018, p. 1)

Phenomenology is a research approach which fits well into the nursing art for nurse researchers. The phenomenological method is used to elicit answers to questions which are fundamental to the science of nursing (Lopez & Willis, 2004). On the other hand, in a study investigating phenomenological approaches used in empirical studies published by nurse researchers, it was stated that there were difficulties attached to phenomenology as a methodology. Among these difficulties, particular attention was drawn to issues such as the nursing researcher focusing on the participant's descriptive experience and not taking into account the particular context in which the participant ascribed meaning. The authors also saw shortcomings in phenomenological commitment. The results of that research showed that there are important differences in many areas such as methodological openness between studies (Norlyk & Harder, 2010). Similarly, the results of articles which discussed the differences between approaches using phenomenology in the literature on nursing show that many researchers did not clearly explain which approach had guided the study. It is thought that this incomplete information could cause difficulties for the reader in how to evaluate the information provided (Lopez & Willis, 2004). John Paley

has focused on the critique of phenomenology for several years and interestingly was heavily critical of the use of phenomenology in nursing research (Zahavi & Martiny, 2019). He claimed that 'nurse-phenomenology', notwithstanding its frequent appeals to classical phenomenology, had little to do with it. Rather than going directly to primary texts, he accused nursing researchers of misinterpreting philosophical opinions, but he overlooked the rich tradition of applied phenomenology which dates back to the early twentieth century and has undergone a significant revival in the last 20-25 years. Furthermore, instead of suggesting that nurses become more familiar with the philosophy on which their research is based, Paley suggested that they should completely abandon their attempts to use phenomenological philosophy (Zahavi & Martiny, 2019).

3.3 Interpretative phenomenological analysis

IPA has both a long and a short background (Smith, Flowers, & Larkin, 2009; Eatough & Smith, 2008). The first real sign of IPA came in an article which Jonathan Smith published in 1996 (Smith, Flowers, & Larkin, 2009; Smith, 1996). The aim was not to come up with one more discipline but to make a claim for a qualitative approach centred on psychology. When IPA started to be talked about in the mid-1990s, it actually received support from concepts and ideas which had a much longer history. This shows that IPA was influenced by important theoretical ideas (Smith, Flowers, & Larkin, 2009).

IPA was designed as an approach to conducting qualitative research (Brocki & Wearden, 2006) which is aimed at exploring how people perceive their life experiences. IPA is phenomenological and is related to the discovery of experience in their existing experience, as discussed above (Eatough & Smith, 2006). The main goal of IPA is to elaborate how individuals understand their private and social lives (Smith & Osborn, 2008).

IPA is defined as a qualitative analysis with a psychological interest in how it makes sense of human experiences. IPA needs the researcher to work with participants to take detailed, reflective and first-person data from them (Larkin & Thompson, 2012). IPA first started in the field of psychology and most of the early studies were in the field of health psychology. Importantly, authors encouraged the use of IPA in human,

health and social sciences and expressed their satisfaction with this situation (Smith, Flowers, & Larkin, 2009). IPA is well known in the discipline of psychology and is increasingly being used in other social and health sciences (Eatough & Smith, 2006). The great majority of studies published using IPA have been in the area of health psychology (Brocki & Wearden, 2006) and more generally in the health field (Shaw et al., 2014; Goldhammer & McCabe, 2011; Biggerstaff & Thompson, 2008; Brocki & Wearden, 2006). Some IPA studies have focused on women's health, such as freebirth (Feeley & Thomson, 2016), childbirth (Tebbet & Kennedy, 2012), pregnancy (Birtwell, Hammond, & Puckering, 2015), pregnancy and postpartum (Burton, 2021), food-related experiences and beliefs (Dibsdall, Lambert, & Frewer, 2002), stroke (Leahy et al., 2016), obesity (Alqout & Reynolds, 2014), same-sex partner bereavement in older women (Ingham et al., 2017), women living with breast cancer (MacLennan et al., 2021) and women living with Type 2 diabetes (Ejegi-Memeh, Hinchliff, & Johnson, 2021). Although IPA is an accessible qualitative research approach, it requires a significant amount of time from the researcher because of the need to work closely with the acquired data (Larkin & Thompson, 2012).

3.3.1 Origins

An interpretative phenomenology is thought to have developed, in particular, from the analysis of social cognition and discourse (Brocki & Wearden, 2006). Social cognition is an approach which focuses on the quantification of the cognitive activity of participants (Eatough & Smith, 2006). Both social cognition and IPA have a shared goal in exploring the relationship between what people think, what they say and what they do (Smith, 1996). The key theoretical foundations of IPA consist of phenomenology, hermeneutics and idiography (Tuffour, 2017). These will be discussed in the following sections.

3.3.2 Phenomenology and IPA

Husserl, one of the main phenomenological philosophers, studied how the observer should set aside his/her prejudices and how the experience gained could emerge (Smith, Flowers, & Larkin, 2009). Husserl's approach to phenomenology was called descriptive phenomenology (Rodriguez & Smith, 2018). For Husserl, phenomenology was about the definition and suspension of our assumptions (such as bracketing off

culture, context or background) in order to obtain a common principle of a given phenomenon (Larkin & Thompson, 2012, p. 102). His phenomenology encompassed an attentive study of human experience (Smith, Flowers, & Larkin, 2009).

Husserl's phenomenology focused on defining the phenomenon by considering only the centre of the human experience and excluding the existing prejudices. Husserl was interested in finding the essence of the experience, whereas IPA tries to capture people's particular experiences. Husserl's work helps IPA researchers to focus on the reflection process (Smith, Flowers, & Larkin, 2009; Eatough & Smith, 2006). According to Husserl's phenomenology, bracketing is needed to maintain objectivity. Within this bracketing, the researcher's prejudices, attitudes, values and beliefs must be suspended so that they do not damage the definition of the phenomenon. The name given to this process in Husserl's phenomenology was 'phenomenological reduction' or 'epoche' (Chesnay, 2014, p. 4). IPA, on the other hand, contrary to this view, argues that it would not be possible to keep our prior understanding and beliefs within the bracket but that they are effective in the interpretation of participants' accounts (Rodriguez & Smith, 2018; Lopez & Willis, 2004). IPA does not see the thoughts, feelings and experiences of researchers as a prejudice. On the contrary, it has the idea that these parts are necessary to make the participants' experiences meaningful (Smith, Flowers, & Larkin, 2009).

The goal of Husserl's phenomenology was to go beyond daily assumptions (Larkin & Thompson, 2012). According to IPA authors, Husserl was interested in finding the essence of the experience, but IPA seeks to ascertain the experiences of particular individuals (Smith, Flowers, & Larkin, 2009). Smith, Flowers and Larkin (2009) argued that most of Husserl's writings on phenomenology are conceptual. Although Husserl provided concrete examples of how the results of the phenomenological method would be, they might not be easy to understand (Smith, Flowers, & Larkin, 2009).

Heidegger (1889–1976) did not accept the theory of knowledge, or epistemology, which underpinned Husserl's work, and instead accepted ontology, which is the science of existence (Rodriguez & Smith, 2018). Heidegger moved away from Husserl's theories and developed an interpretative approach which became known as the hermeneutic tradition (Balls, 2008; Eatough & Smith, 2006).

3.3.3 Hermeneutics and IPA

The second important theoretical basis of IPA is hermeneutics (Tuffour, 2017; Smith, Flowers, & Larkin, 2009) which is "the theory of interpretation" (Smith, Flowers, & Larkin, 2009, p. 21). Hermeneutics is the interpretation of art and science and can also be defined as 'meaning'. Meaning is something which is constantly open to new understanding and interpretation, rather than something which remains fixed. As a result, hermeneutic phenomenology is defined as the study of experience with meanings (Tuffour, 2017). Merleau-Ponty was primarily interested in an embodiment and Heidegger and Sartre were more centred upon existential issues (Smith, Flowers, & Larkin, 2009).

In the same way, it is argued that hermeneutics is the theory of interpreting human behaviour (Holloway, 1997) and Heidegger stated that "an interpretation is never presuppositionless apprehending of something presented to us", so "the reader, analyst or listener brings their fore-conception (prior experiences, assumptions, preconceptions) to the encounter and cannot help but look at any new stimulus in the light of their own prior experience" (Smith, Flowers, & Larkin, 2009; p.25). Contrary to the descriptive approach, the hermeneutic approach is used to investigate the contextual features of experience (Matua & Van Der Wal, 2015). Interpretative phenomenologists have stated that it is impossible to approach something completely unprejudiced and neutral. Instead, they argued that we use our own experiences when interpreting those of research participants (Clarke, 2009; Balls, 2008).

Heidegger provided recognition of what the existential turn is in phenomenology and his goal was to understand existence. Heidegger claimed that the idea that 'being' always presupposes the being of something. Heidegger used the German word *dasein* for this kind of being (Davidsen, 2013, p. 322). *Dasein* is not easy term for expressing human existence and it has often been defined as 'being-there', 'the being of the there' or 'being-in-the-world' (Sturgess, 2016, p. 24). *Dasein* is about how the world is viewed by us and how it becomes meaningful through our interaction with others (Sturgess, 2016; Davidsen, 2013).

The main features of Heidegger's explanation of *dasein* were lived time and an engagement with the world, and Heidegger also emphasized that interpretation is the

unchanging way to get to these things. Heidegger formulated phenomenology as an explicitly interpretative activity (Smith, Flowers, & Larkin, 2009).

Ricoeur connected phenomenology and hermeneutics by explaining that experience and its meaning are intertwined (Tuffour, 2017; Henriksson, Friesen, & Saevi, 2012).. According to Ricoeur, meaning is indispensable to experience (Tuffour, 2017; Henriksson, Friesen, & Saevi, 2012). Ricoeur devised two forms of hermeneutics, the hermeneutic of empathy and the hermeneutic of suspicion, based on Heidegger's definition of hermeneutics. The first approach seeks to reconstruct the original experience in its own terms, whereas the second uses theoretical perspectives from the outside to shed light on the phenomenon and looks at the material from a more remote view, like psychoanalysis or Marxist theory (Davidsen, 2013; Smith, Flowers, & Larkin, 2009; Ricoeur, 1970). In IPA, interpretation is not made by applying a separate theoretical approach as in the hermeneutics of suspicion. Instead, IPA occupies a middle location between the hermeneutics of empathy and the hermeneutic of suspicion. Interpretation can be at various levels in IPA and the depth of the levels increases as research progresses (Davidsen, 2013).

Interpretation in IPA is based on the text. Researchers using IPA employ an inquiry technique, both in the light of external theories and as seen from outside the participant, in order to understand the participant's experiences and interactions (Davidsen, 2013). In other words, they adopt an enquiring, critical and interpretive approach to understanding what the participants are talking about and provide a perspective which the participants might not see themselves (Davidsen, 2013; Smith, Flowers, & Larkin, 2009; Eatough & Smith, 2008).

It can be said that IPA is more identified with the views of Heidegger, Ricoeur, Merleau-Ponty and Sartre than with descriptive phenomenology (Tuffour, 2017). IPA is heavily influenced by the hermeneutic version of phenomenology. Trying to get as close as possible to the participant's individual experience is phenomenological, as well as recognizing that it becomes an interpretative effort for both the participant and the researcher. There would be nothing to interpret without phenomenology, whereas the phenomenon could not be seen without hermeneutics (Smith, Flowers, & Larkin, 2009).

Hermeneutics is a significant component of intellectual history, as well as providing

major theoretical information for IPA. IPA is an interpretative phenomenological approach and therefore it is important to clearly define phenomenology as a hermeneutic enterprise, as Heidegger did. IPA, following Heidegger, is about how a phenomenon arises, and the analyst is involved in facilitating and making sense of that view (Smith, Flowers, & Larkin, 2009).

3.3.4 Ideography and IPA

Idiography and hermeneutic phenomenology are two major elements of IPA (Larkin & Thompson, 2012). The word 'idiography' is derived from a Greek word meaning 'to describe an individual, unique person or events' (Holloway, 1997, p.91). The idiography of IPA is usually more focused on individuals rather than the universal (Eatough & Smith, 2008). IPA wants to know in detail how the experience is for the person (Eatough & Smith, 2006). IPA focuses on the individual contrary to the nominal approach which is related to making claims at the group or population level and establishing general theories of human behaviour (Smith, Flowers, & Larkin, 2009).

So IPA is decisively idiographic unlike the nomothetic principles of many psychological empirical techniques. There are two levels of IPA in this regard. The first is an expectation of detail and depth of analysis. As a result, the analysis should be comprehensive and systematic. Second, IPA is committed to understanding a particular event or participant's situation (Smith, Flowers, & Larkin, 2009). IPA therefore uses small, purposive sampling methods and cautiously selected samples (Smith, Flowers, & Larkin, 2009). Idiographic methods openly address human emotions, thinking and action in order to gain a better understanding of the phenomenon studied (Eatough & Smith, 2008). It is of great importance that researchers using the idiographic approach follow it meticulously. An idiographic approach is necessary to examine in detail the divergences and convergences between the experiences of the participants (Tuffour, 2017).

3.3.5 Justification for using IPA in this thesis

I decided to adopt IPA to explore this research area for a number of reasons. As I explained above, the qualitative research design was regarded as appropriate when the aim and objectives of the thesis were considered, and IPA gives the researcher

insight into participants' experiences of the phenomenon under study (Clarke, 2009; Brocki & Wearden, 2006; Larkin, Watts, & Clifton, 2006). By taking the IPA approach, I was able to understand the menopausal experiences of women and their perceived effects on women's interpersonal relationships and intimacy (Smith, Flowers, & Larkin, 2009). As far as I am aware, IPA has not previously been used to explore this topic with menopausal women.

In addition, IPA is about how participants understand their own experiences. This requires a dialogue between a participant's own understanding of her own experience and the interpretation of the analyst. This implies that reflexivity is embedded in IPA, meaning that the data and the meaning of the data in the analysis are considered together (Shaw, 2010) and this has been described as 'double hermeneutics'. The IPA researcher can be said to be dealing with double hermeneutics because s/he seeks to make sense of the efforts of participants to make sense of what is happening to them (Smith, Flowers, & Larkin, 2009, p.3). Reflexivity is also recognised as important throughout the whole research process. This methodology is influenced by the interpretation of the experience of a particular person in a particular context. It draws attention to the subjectivity of people and how they understand their own unique experiences (Smith, Flowers, & Larkin, 2009).

3.3.6 Alternative methodologies considered and rejected

I considered other qualitative approaches but did not deem them suitable for this thesis. The reasons for rejecting alternative methodologies during the project planning phase were as follows. Grounded theory (GT) is an approach which seeks to develop a theoretical account of a particular phenomenon (Smith, Flowers, & Larkin, 2009). It was developed to understand and explain the different social processes (Willig, 2013). Researching social processes requires emphasis on understanding at the group level. On the other hand, the fact that IPA is an idiographic focus on one of the related fields influenced me to choose IPA. Furthermore, due to the complexity of the menopause and human relationships, IPA was chosen over GT so that a more in-depth understanding of individual women's experience of the menopause within the context of their relationships might be realized. I did not wish to develop a theory about the menopause. Furthermore, GT generally requires a larger sample than IPA. GT is

aimed at the macro-level theoretical conceptualization of a phenomenon based on a broader sample whereas IPA focuses on the micro-level nuances of a smaller sample.

Discourse analysis was a potentially suitable research methodology. It is concerned with how language is used to build resources which serve to facilitate interpersonal goals in social interaction (Willig, 2013). There are two main versions of discourse analysis, discursive psychology and Foucauldian discourse analysis (Willig, 2008 p. 95). Discourse analysis was examined as to whether it was appropriate for this thesis, but it was not suitable because this thesis does not focus on linguistic understanding. This thesis is largely concerned with understanding the participants' experiences of the menopause and their relationships in detail rather than how language about the menopause is used to influence relationships. Although women's experiences and understandings may have been influenced by different discourses, I did not want to limit the analytical stance only to the effect of discourse, so an IPA approach seemed more appropriate.

3.3.7 Reflexivity

In qualitative research, reflexivity refers to researchers involved in a clearly "self-aware meta-analysis" (Finlay, 2002, p.209). From the point of view of current practice, it can be stated that reflexivity is seen as a "defining feature of qualitative research" (Finlay, 2002, p.211). The reflective process encourages the researcher to talk about the interaction of their individual feelings and thoughts on the research (Denzin, 1997). In addition to this, we should reflect on how we control this situation at every step of the research. In this way, the researcher will be able to become more open about own role. According to Clancy (2013), although reflexivity is a difficult process, it is also an important process in terms of the researcher's self-awareness and seeing the effects that will affect data collection and analysis.

Reflexivity, which is one of the criteria for trustworthiness of research, is seen as a preliminary reflection process about the researcher's own prejudices, preferences and relationship with the research (Korstjens & Moser, 2018; Guba, 1981). The IPA recognizes that the researcher's assumptions may hinder as well as be helpful in interpreting the lived experience of others (Shaw, 2010). In IPA, symbolic interaction actually means that the researchers are aware of the role they play in producing and

analyzing data. Also, IPA is recommended for studies on sensitive subjects, especially those aiming to biopsychosocial findings (Biggerstaff & Thompson, 2008) The importance of reflexivity in qualitative studies has been emphasized in many publications. In the IPA, when the researcher is thinking about the accounts of the participants, it ensures the researcher thinks about how their experiences, beliefs and feelings affect the study, and how the researcher would evaluate the data from this point of view. I think I benefited from this approach in my research. For example, at the points where a woman has to do something she doesn't want just because the man wants it, as a researcher, I realized that I focused more on the reason for this situation. Because I believe that men and women should be equal in terms of their rights and liberties, even if they are different in many respects. In this way, I can say that I paid extra attention both during the interview and during the analysis to reveal the underlying causes in the women's experiences and behaviours.

I introduced myself as a researcher in the Preface section. This is where I presented my own awareness of its place in the study. I gave an idea about the effects I can bring on the research process from my professional life and personal life. During the research process, I questioned myself about how my beliefs, previous life experiences and views had an impact on the planning of the study. For example, I wrote down my thoughts on how I could better understand her experiences with a woman of a different race whom I did not know at all, and I read them occasionally in the analysis process, reminding myself of them and pushing them to think again and again. I also thought about the basic assumptions I have about the data that I can obtain in this study. For example, I knew beforehand that women could experience a lack of sexual desire due to menopause. However, I didn't have much foresight about the very different problems they might have with their partners. That's why, even though I couldn't think about it deeply in the first interviews, I realized this early and it caused me to think about the interview questions and from a broader perspective. The reflexivity also led me to ask myself some questions. For example, where am I in this research? Did moral and individual experiences influence my perception of the participants' experiences? It encouraged me to think about discovering my position in research by asking those questions.

I think that my professional work as a midwife and nurse for more than 10 years may have had a positive impact on my data collection and analysis. Because, since I have

contacted so many women before, I think that I knew the communication barriers beforehand and so did not experience these problems with my participants. Moreover, when I talked to them, I encouraged them to express themselves and tried to get them to take part in a mutual conversation as if it is not a one-sided question and answer during the interview so it caused them to express themselves better.

In addition to my professional work, I received education on women's health since high school so my previous knowledge and experience may have affected my study. For instance, during my midwifery and nursing education and in my working life, I realized that birth and maternity issues were prioritized for women's health, and this was actually one of the reasons for doing my doctorate on this subject. I believe that the health of women of all ages, especially their sexual well-being, is important, so I think that I have made an effort to make this subject more understandable while collecting data in line with these feelings and in my analysis process throughout this study. For this, for example, I wanted to try to get more detailed and clear answers from women. I asked myself questions about how to convey women's experiences to the reader in the clearest way. Furthermore, while I was listening to the problems or experiences of women during the data analysis, it made me question why I couldn't foresee them as a healthcare professional before. To ensure that I was reflecting throughout the research process, I wrote the reflectivity section (see Chapter 6 – Discussion).

3.3.8 Rigour

To ensure the trustworthiness of the study, I followed the four criteria for the trustworthiness of qualitative research designed by Lincoln & Guba's (1985). The four criteria have been proposed in qualitative research are: credibility, transferability, reliability, confirmability (Korstjens & Moser, 2018; Forero et al., 2018; Lincoln & Guba, 1985).

1. Credibility: Credibility is about providing confidence that the results (from the point of view of the participants) are accurate, reliable and convincing (Forero et al., 2018; Lincoln & Guba, 1985). It includes that the information generated from the original data of the participants and the correct interpretation of the original opinions of the participants (Korstjens & Moser, 2018).

The steps I took in this thesis to achieve credibility:

I had knowledge in this field through undertaking a literature review and reading the understanding of menopause and sexuality. It provided me with familiarity with the setting. I also attended an IPA workshop at the University of Derby to learn skills in IPA analysis technique.

I used reflection diaries throughout the processes of data collection and analysis and these help to these helped to interpret correctly women's accounts

My supervisors also analysed one of the interviews so we could check we understood what the participant was saying, that our interpretations of her words were similar. This, alongside regular detailed discussions with my supervisors regarding the analysis process enabled important contributions to be made in the analysis and interpretation of the data. My supervisors contributed to the reliability of the data by asking me to explain how I interpreted the participants' data and why I interpreted it that way.

During the data analysis process, I read and listened repeatedly to all 14 participant transcripts to not miss any meaning or word.

2. Transferability: Transferability is about the applicability of the findings to other contexts (Forero et al., 2018; Lincoln & Guba, 1985). Researcher's responsibility for transferability should be provided with a thick description of the participants and the research process so that the reader can understand whether it is possible to transfer them to their setting. It means that the decision of transferability is a decision for the reader to make (Korstjens & Moser, 2018).

The steps I took in this thesis to achieve transferability:

In order to provide sufficient contextual information for other researchers, I explained in detail information about the participants and the interview settings and the whole process of data collection and analysis (Chapter Four – Methods and Appendices from Appendix 4.1 to Appendix 4.16). This should enable researchers to decide if the findings are transferable to other settings. Moreover, in Chapter Five – Findings, data with plentiful participant extracts were presented, this can provide the reader idea about transferability.

3. Dependability: Dependability is checking that the data analysis conforms to accepted standards for a particular design and the steps taken are clearly stated for

evaluation by external auditors (Korstjens & Moser, 2018; Guba, 1981). In order to address dependability, it is important for the researcher to document the processes in the study in detail to the reader, to ensure that a future researcher will repeat the study even if not needed to achieve the same results (Shenton, 2004).

The steps I took in this thesis to achieve dependability:

I provided detailed information about the steps of the study process (Chapter Four – Methods and Appendices from Appendix 4.1 to Appendix 4.16), in this way, to provide opportunities for those who want to do repeat work.

Throughout the thesis, I added supportive quotes (Chapter Five – Findings) to allow the reader to affirm what they have read in this thesis is an accurate interpretation of the data.

4. Confirmability: Confirmability refers to that the existing data and interpretations of the findings obtained after the study are not the product of the researcher's imagination, on the contrary, they are clearly derived from the data (Korstjens & Moser, 2018; Lincoln & Guba, 1985).

The steps I took in this thesis to achieve confirmability:

The interpretations presented in this thesis and the findings obtained are based on women's accounts and the ideas of the participants. To ensure it, I have included great plentiful descriptions using participants extract (Chapter Five – Findings). The accuracy of the interpretation had been checked by the supervisor team.

Summary of the Methodology Chapter

In this chapter I have provided a justification for the use of a qualitative approach in general and IPA in particular as suitable for the topic of study. In the following chapter, I shall describe how I conducted the research, including sampling and recruitment, the data collection and analysis process, and ethical considerations.

CHAPTER 4: METHODS

Introduction

In the previous chapters, information about the importance of this research, including why it is necessary and how it can be beneficial, was presented. In this chapter, I shall explain in detail how the research was conducted and the processes followed, including the sampling and recruitment of participants, data collection, the steps of data analysis and the procedure for acquiring ethical approval. In order to address the aim of the thesis, which is 'to explore post-menopausal women's experiences of the menopause and the perceived impact which the menopause can have on their interpersonal relationships and intimacy and the coping methods used' and to meet the objectives set out in the previous chapters, semi-structured interviews were conducted. Smith, Flowers and Larkin (2009) stated that semi-structured interviews are one of the most appropriate ways for data to be collected in IPA.

4.1 Sample and sampling

As informed by the literature review findings and to meet the aims and objectives of the thesis, an appropriate sample was decided on. Women whose most recent menstrual period was over twelve months previously and post-menopausal women aged up to 70 years were included; the inclusion and exclusion criteria are set out in section 4.1.2.

This thesis was planned to be carried out with 10-15 women. Smith, Flowers and Larkin (2009) recommended that the number of participants for an IPA study is usually small because IPA produces highly detailed analyses which take a long time. The number of participants for an IPA doctoral theses can vary according to the specific time constraints on the thesis and the richness of the individual cases (Eatough & Smith, 2008; Smith & Osborn, 2008). The idiographic emphasis of IPA and the goal of this thesis to obtain in-depth, high-quality information which would enable a thorough exploration of the participants' experiences determined the sample size (Clarke, 2009; Eatough & Smith, 2006). It has also been suggested that the sample should be as homogeneous as possible since IPA does not enable generalizations to be made (Pietkiewicz & Smith, 2012; Clarke, 2009; Smith & Osborn, 2008). The definition of

homogeneity for IPA can vary depending on the nature and topic of the research. For example, if a study population is too large, a number of socio-demographic characteristics would have to be taken into account. 'Homogeneous' means that the sample is closely defined because the participants represent a perspective not a population (Smith, Flowers, & Larkin, 2009).

Sampling should be consistent with the orientation of IPA. This means that instead of the probability methods, purposive sampling should be chosen because it can provide "insight into a particular experience" (Smith, Flowers, & Larkin, 2009, p.49) and to ensure that participants with experience of the research area are recruited. Purposive sampling is a non-probabilistic sampling procedure and is a method in which the target population is selected according to the objectives of the thesis and whether it fits for the particular inclusion and exclusion criteria which have been set (Daniel, 2011).

Purposive sampling in this thesis meant that the participants were selected according to the inclusion criteria in order to meet the aim and the goals of the thesis (Willig, 2013). Some of the strengths of purposive sampling over other non-probability sampling methods are that there is less possibility of selection bias, less bias in terms of under-representation or over-representation, and that it is more suitable for research focusing on specific segments of the target population (Daniel, 2011).

4.1.2 Inclusion and exclusion criteria

Determining the inclusion and exclusion criteria of the sample was an important step in achieving the aim and objectives of this thesis. I decided to include post-menopausal women in the thesis due to the lack of existing research as explained in the literature review. In addition, homogeneous sampling is recommended for IPA (Smith, Flowers, & Larkin, 2009).

The inclusion criteria used to determine the suitability of the participants::

- post-menopausal women (no menses for at least twelve months) any woman who identified as being in post-menopause;

Since there is a absence of research in this area, was focused on postmenopausal women.

- aged up to 70;

The upper age limit was set because women can experience menopausal symptoms for many years after the menopause, and this age criterion enabled me to capture the experiences of women who are rarely represented in qualitative research into the experience of menopause.

- no minimum age requirement was set;
- able to read, understand and speak English;

Only women who could read, understand and speak English since were recruited, so that I knew that they could understand the details on the Participant Information Sheet, and give their informed consent to participate (see Appendix 4.1);

- voluntarily willing to take part in the thesis;
- had a lived experience of a natural menopause;

The reason for inclusion of women who are experiencing natural menopause is because their experiences can differ from those who experience surgically induced menopause such as after a hysterectomy or cancer. Women can experience the menopause at a very young age, and when sudden the menopause occurs, the psychological and physiological effects can be different. In addition, these women might have different problems for many reasons, such as severe menopausal symptoms. This would change the outcome of the study.

The exclusion criteria were:

- unable to read, understand and speak English;
- not post-menopausal;
- not experiencing a natural menopause; and
- over 70.

No criteria were set in regard to marital status, ethnic group or sexual orientation in order to explore the similarities and differences between women with different lives and backgrounds and to ensure that the experience of all types of women in society was included in this thesis.

4.2 Recruitment

When I began to research how and where to find appropriate participants, I came to know about the Menopause Cafe from my supervisor. I met the pioneers working in

the Menopause Cafe and obtained information about the cafe from them. After I had realised that I could recruit suitable participants for my thesis there, I made some connections and started negotiating in line with the appropriate ethical considerations.

The Menopause Cafe is a voluntary organization which was established so that women can receive peer support as well as discuss issues such as products, information or services about the menopause. The idea of a Menopause Cafe was developed by Rachel Weiss and the world's first Menopause Cafe opened in Perth, in Scotland, in June 2017. There is no regular timetable for the Menopause Cafe although some Menopause Cafe events do occur on a monthly basis. Looking at the activities of the menopausal cafe movement over the last twelve months, it can be seen that events have taken place in different UK cities such as London, Edinburgh and Sheffield; there have also been activities in Canada (Menopause Cafe, 2018). I had the opportunity to communicate with key people involved in the organisation of a local Menopausal Café primarily by telephone, then by mail and then by a visit to a menopause café to introduce my doctoral thesis to its members. There was interest in the topic and they wanted to know more; this helped with the recruitment of research participants after ethical approval had been sought and received (see section 4.5 for details about the ethical considerations).

Because direct recruitment to research studies is not allowed through the Menopause Cafe movement (see <https://www.menopausecafe.net/>), I attended a pre-meeting at one Menopause Cafe to introduce myself and share details of my work with the organisers of the cafe. They welcomed me to stay and listen to the women talking at the cafe, and it was insightful for me to hear about the women's experience. Following that, information about my thesis was shared by the social media managers of the Menopause Cafe. Volunteers were invited to participate in the thesis. These advertisements were posted on both the general Menopause Cafe Facebook account and the Sheffield Menopause Cafe Facebook account (they are shown in Appendix 4.2).

The organisers of the Menopause Cafe also helped to find participants by sharing information about my thesis on their Facebook page. Women who were interested sent an email to the Menopause Cafe staff and then either the staff contacted me or the women contacted me directly. In addition to the emails which I received through

the Menopause Cafe in this way, some of the participants stated that they had shared my information with their relevant neighbours, friends and members of some of the groups which they had joined. In this way, I was able to communicate with women from different circles and not just with women who attended the Menopause Cafe.

The majority of the potential participants sent messages by email (some of them directly to me some of them to menopause cafe firstly which were then forwarded to me) and some stated that they had been interested by reading about the thesis on Facebook and wanted more detailed information about it and that they would participate if it was suitable for them. In addition, during the correspondence, I discussed the eligibility criteria with potential participants in order to be sure that they were suitable for inclusion in the thesis. I gave them detailed information about the thesis and sent the Participant Information Sheet (see Appendix 4.3) and the Consent Form (see Appendix 4.4) and told them that if they had any questions, they could ask them freely. In this way, I could ensure that their involvement was completely voluntary.

4.2.1 Further details about the recruitment process

I spent considerable time and energy reaching out to participants because the sensitivity of the subject made me concerned to find women who were both eligible and willing to participate in this thesis. After women had contacted me to express an interest, I made detailed notes about them and I replied to their messages quickly. I took notes after every e-mail or message which I received and took care to make an appropriate response to every women. I gave them information about how and in what form the thesis would be written and answered many questions from them. As a result of sharing information about my thesis in the ways described above, I received messages from a total of 40 women stating that they were interested in the thesis, asked for information and expressing an interest in participating. The process by which I reached an eventual sample size of fourteen participants is described in the following section.

From the Menopause Cafe event

After I had attended the Menopause Cafe, thirteen people informed the organisers that they were interested in the research topic. After I had received ethical approval for the

thesis, I contacted the Menopause Cafe to reach these thirteen potential participants. First, I sent them the Participant Information Sheet and Consent Form. I wanted them to have all the information and to make a clear decision to participate in this thesis and these documents would help them to understand the thesis topic and give them time to decide whether to participate or not. One of these thirteen women stated that she did not want to talk about sexuality, so she could not be included. Even though two other people had initially stated that they were willing to participate, they did not respond to subsequent emails and therefore could not be included.

One man said that he wanted to be a participant in order to inform me about male menopause and andropause, and said that if there were any further studies, he would like me to have this information. He was excluded because my thesis focused solely on women's experiences of the menopause. Another four women were not recruited because one had had surgery, one did not have the time and two were still experiencing menstrual periods. In total, therefore, eight of the thirteen potential participants could not participate and the remaining five stated that they were still willing to participate. After further communication to confirm that they all met the inclusion criteria, we continued to communicate in order to arrange a date and time for interview.

While this process was going on, I continued to communicate with other women who had expressed a willingness to participate. I received messages from a total of 27 women stating that they were willing to participate and some of them wanted to learn more about the thesis. They were recruited in the ways outlined below.

From friends

Five women said that they had heard about the thesis topic from their friends and wanted to volunteer. One of them, however, said that she would be out of the city and therefore unavailable for interview and another said that she did not have time to continue with the emails. The remaining three women met all the inclusion criteria, and a day and time were arranged for an interview with them.

From Menopause Cafe social media

In the days after the meeting, the Menopause Cafe continued to share information on social media that potential participants were being sought. This produced five

messages and emails from women stating that they were willing to participate. One could not participate, however, because of ovarian cancer leading to a hysterectomy and another still had menstrual bleeding. A third woman initially said that she was willing but she did not respond to any subsequent emails. Three of the five women could therefore not participate, but further emails with the remaining two showed that they met the inclusion criteria so dates and times were arranged for interviews with them.

From the volunteer mailing lists in which they were involved

I received emails from ten women who said that they were included on the volunteer mailing list and that they were very interested in this thesis subject as a result of some of their friends telling them that participants were being sought, and that they had wanted to participate as soon as they saw it. One of these women sent the following e-mail:

Also, apologies for not getting in touch sooner but unfortunately I will no longer be able to take part in your research. I wish you luck and every success in the future.

Of the remaining nine women, three did not respond to subsequent emails and therefore could not participate. Four of the remaining six women did not meet the inclusion criteria: one had breast cancer, one still had menstrual bleeding and two had undergone menopause after a hysterectomy. The remaining two women did meet the inclusion criteria so places and times were arranged for interviews with them.

From their close circle (from the social media groups which they had joined)

Three women stated that they were aware of this thesis from the Facebook posts made by their close circle or friends. They sent messages expressing their willingness to participate as they considered this thesis topic to be very important. One did not respond to subsequent emails and so did not participate. The remaining two met the inclusion criteria and were recruited as participants.

Some of them said they could not remember where they heard it

Four women sent me emails volunteering to be participants. When I asked them how they had heard about this thesis, they said that they could not remember. One woman

subsequently stated that she had initially been willing but that she had acquaintances at the university and was afraid to talk about such a specific subject. Another woman could not participate because she said that she had had a mastectomy and that her ovaries had been removed:

I'm 50 now but menopause was brought about through the removal of my ovaries at 45 when I had a preventative mastectomy too.

The remaining two women did not respond to emails later and thus could not be interviewed. So although there had initially been 40 volunteers, fourteen eligible participants were identified. The recruitment process is summarized in Figure 4.1.

4.3 Data Collection

4.3.1 Setting

The interviews took place at each participant's proposed location (such as their home or an office in the University), and I paid attention to the privacy, comfort and safety of both the participant and me. When deciding on the place and time of the meeting, I first considered the participant's suggested location, date, and time. I gave the participants flexibility over this and even adapted to last-minute changes and postponements requested by them.

During the interviews, I took care to provide a safe and comfortable environment for the participants to talk and share their special knowledge and experiences. This situation was important for the quality and dependability of the data obtained and for the participants to be happy at the end of the interview. In qualitative studies, the term dependability is preferred to reliability (Lincoln & Guba, 1985).

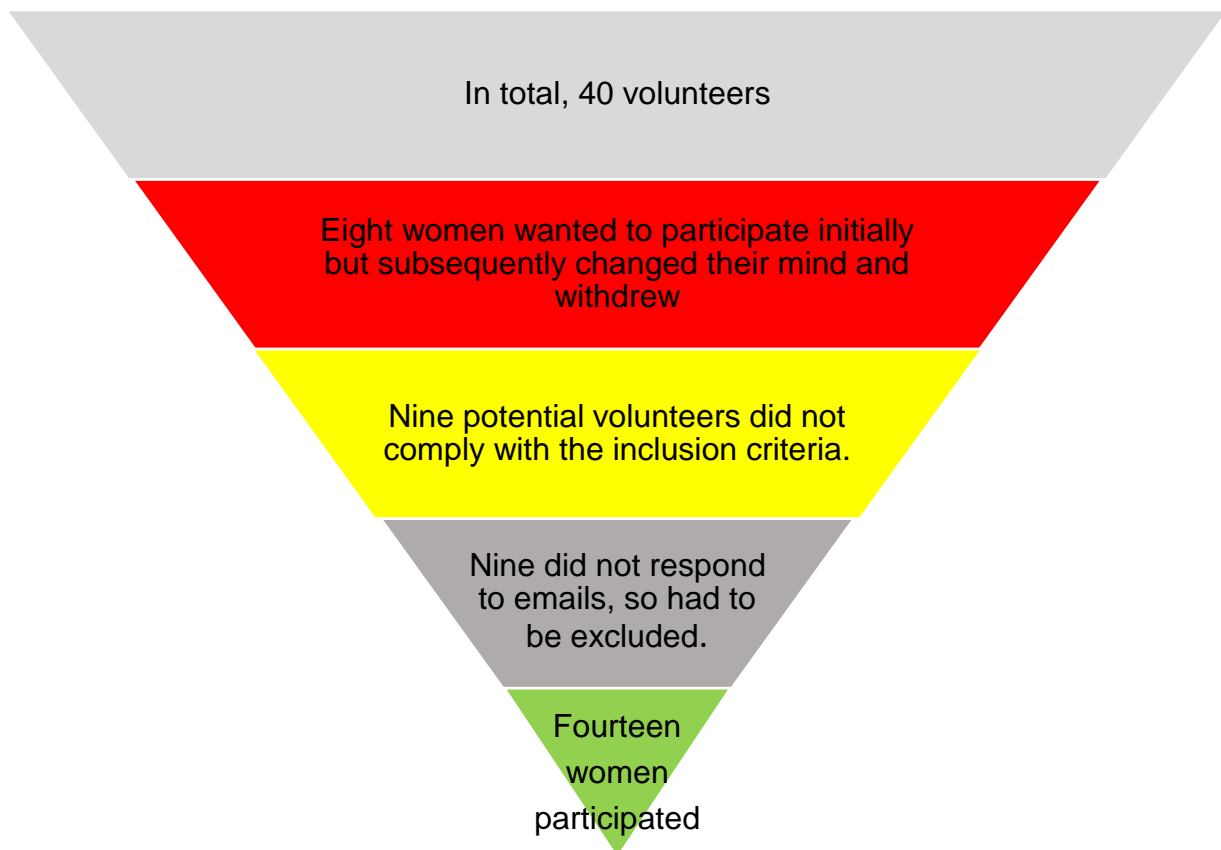
At the request of five participants, I met them at their homes and a suitable environment was provided for me to talk to them alone. They also made me feel comfortable in their homes; I felt as if we already knew each other. I think that this was effective in enabling me to communicate with them and to answer their questions sincerely. They consistently offered various treats to eat and drink and they were always kind to me. I had the opportunity to have a long conversation with them before turning the voice recorder on and I believe that this helped me to develop a relationship with the women.

One of the participants wanted to meet at her workplace and told me that there was a suitable room there. There was no problem due to the absence of anybody else in the workplace during the meeting. One participant wanted to meet at a cafe of her choice in the shopping centre. I wanted to avoid crowds and noise by preferring to meet her in the early hours of the weekend and I went to the cafe before she arrived and made sure to choose a suitable table in a far corner of the cafe which provided a level of privacy and a comfortable speaking environment. One participant who lived outside the city wanted to meet in Sheffield city centre and we conducted the interview in a room at the University.

During the interviews in rooms at the University, I made the necessary preparations by going to the room beforehand. I put signs on the door to prevent anyone from entering and interrupting the interview. I gave flowers to participants as a thank-you gift for participating. I served refreshments during the meetings, offering them some homemade cookies, Turkish coffee, water and tissues to welcome them and help them to feel more at ease. Photographs taken during the data collection can be seen in Appendix 4.5. I believe that all these preparations helped the participants to feel comfortable and therefore helped them to talk to me about this private topic. For example, while drinking Turkish coffee together, we stopped being two strangers and had the chance to talk like friends about Turkish coffee and different subjects, and this enabled us to develop a mutual communication. I shall discuss this further in the section on reflectivity.

Four meetings were held on Skype and I paid attention to helping the participants to feel that they were in a comfortable and safe environment by booking University rooms in advance. I went to each interview room beforehand, prepared the internet link and the necessary equipment and checked that they were working. I hung Do Not Disturb notices on the door stating that an interview was taking place. In addition, in all of the interviews, especially in the Skype interviews, I took care to arrange the seating in the room so that others could not overhear what was said. Appendix 4.6 is a table showing where and how the interviews took place, together with the time and duration of the interviews.

Figure 4. 1: The recruitment process



After identifying these fourteen eligible participants, meetings with other potential participants were suspended and I told further volunteers that enough participants had been recruited and that they would be put on a waiting list.

4.3.2 Collecting the participants' demographic details

I asked the participants demographic questions at the beginning of their interview after obtaining their consent. These questions covered their age, education level, religion, ethnicity, employment status, social class, postcode (rural or urban area), children, relationship status, the gender of partner, menarche age, time of entering the menopause, health condition and any medicines taken (see Appendix 4.7). This is an effective way of creating a snapshot of participants and enables researchers to aggregate various key demographic features efficiently (Aurini, Heath, & Howells, 2016). In addition, these demographic questions helped to develop a information about

each participant and give myself and the reader provided a context into which the data analysis could be placed. By starting with these questions, I was able to build a relationship of trust which greatly eased the interview questions which followed.

The demographic characteristics of the fourteen participants are presented in detail in Table 4.1 and more detailed information is provided in Appendix 4.8. In order to protect the anonymity of the participants, personal information such as their postcode, their work and the exact dates of birth and the genders of their children have been removed from the demographic information table. The demographic details were kept in a safe, locked private locker which only I could access, as described in the ethical considerations section 4.5.

Table 4. 1: Demographic information of participants

No	Participants' pseudonym	Age	Location	Employment status	Social class	Ethnic origin	Relationship status	Gender of partner	Menarche age	Age on entering menopause
1	Angela	51	Sheffield	Part-time	Working	White British	In a relationship	<i>Past:</i> Bisexual <i>Now:</i> Male	11	49
2	Belinda	49	Nottinghamshire	Part-time	Working	White British	Married	Male	12	42
3	Camila	47	Sheffield	Part-time	Working	British Asian	In a relationship	Male	14	38
4	Dawn	56	Sheffield	Full-time	Working	White British	Divorced	Male	11	39

5	Elizabeth	58	West Sussex	None	Working	White British	In a relationship	Male	13-14	53
6	Fiona	64	Sheffield	Full-time	Middle	White British	Married	Male	10	50
7	Gina	57	Sheffield	Part-time	Middle	White British	Divorced	Male	11-12	50
8	Helen	60	Sheffield	Part-time	Middle	White British	Divorced	<i>Past:</i> Male <i>Now:</i> Female	10	50
9	Isabel	49	Wakefield	Full-time	Working	White British	Married	Male	14	45

10	Julie	57	London	Retired	Working	White British	Married	Male	14	51
11	Kath	56	Liverpool	Full-time	Working	White British	Divorced	Male	11-12	50
12	Linda	56	Sheffield	Self-employed, part-time.	Middle	White British	Married	<i>Past:</i> Male and female <i>Now:</i> Male	12	53
13	Mary	56	Liverpool	Part-time	Middle	White British	Married	Male	14	54
14	Nancy	59	Sheffield	Retired	Working	White British	Married	Male	14	49

4.3.3 Semi-structured data collection

In IPA, unstructured interviews are not suitable because, as Smith, Flowers, & Larkin (2009) note, IPA study requires a wealth of information therefore, participants need to be given the opportunity to easily express their own stories, ideas, and concerns (Smith, Flowers, & Larkin, 2009). Semi-structured interview allows empathy between the researcher and participant and it facilitates rapport between them. Also, it provides greater flexibility, allows viewpoints to enter new areas, and helps produce rich data (Smith & Osborn, 2008). In addition, researchers can gather similar kinds of information from all participants thanks to semi-structured interview because researchers can prepare questions in the direction of the research question and ask participants. In this way, they save time (Holloway & Wheeler, 2010).

Diaries and written personal accounts can be used as a data collection method in IPA (Smith, 2004) but the usage rate is very low (Smith, Flowers, & Larkin, 2009). They were not selected as data collection method for this thesis because the real-time interaction with the participant provides great flexibility in helping the researcher in discovering the participants' life experience (Eatough & Smith, 2008).

Although observational methods are the basis of ethnographic and many kinds of research, they were not appropriate for this thesis. Permission and access for observational study is difficult compared with other forms of data collection (Holloway & Wheeler, 2010) and, most importantly, observational methods were regarded as totally inappropriate because of the sensitive focus of the thesis (it would be entirely unethical to observe women and their partners during intimate moments).

Focus groups are also inappropriate method of data collection for IPA researchers because they presents a very complex interaction environment (Palmer et al., 2010). Additionally, a focus group is not suitable for gathering in-depth information at the individual level (Morgan, 2012). Moreover, women often view sexuality as a private topic and do not want to share their problems even with their friends and partners in some studies.

I chose to use semi-structured interviews as the data collection method because they are the recommended data-collection method for IPA (Eatough & Smith, 2008). The

goal of a semi-structured interview schedule is to create a rapport between participant and researcher and enable rich and detailed information about experiences to be obtained (Smith, Flowers, & Larkin, 2009).

The semi-structured interview schedule was prepared in accordance with the aim and objectives of the thesis, the key issues and deficiencies identified in the literature review, and the directions proposed by IPA. The interview schedule was finalized after discussions with my supervisors, their suggestions and the exchange of ideas. Suggestions for data collection in the IPA methodology were also considered while creating the interview programme. Some of the most important aspects included open-ended questions and statements to ensure that the answers obtained were suitable for analysis (Smith, Flowers, & Larkin, 2009). In addition, questions and prompts were created to encourage participants to speak (see Appendix 4.9). When I was preparing the semi-structured interview schedule, I realised that it would be difficult for participants to talk about sexuality at the beginning of the interview so I placed such questions in the middle of the interview.

I thought that it would be more helpful to talk about the effect of the menopause on sexual life and interpersonal relationships first by establishing mutual trust by talking about more general the menopause experiences, and also after getting to know the interviewee's experience of the menopause. As a matter of fact, I realized the benefit of this throughout the interviews. It would have been too superficial for me to talk about more sensitive issues without having any knowledge of a woman's experience of the menopause. It was an important point, as I stated in the background section, that the symptoms of the menopause form a chain and are frequently interconnected. For example, knowing that the woman was experiencing vaginal dryness made me aware of talking about the impact on her sexual life. Without knowing this, talking to the participant would be outside the overall perspective on the menopause and I would not have sufficient data about the participant or be able to establish connections.

During the interviews, I paid particular attention to my own body language and facial expressions as well as to my verbal communication. I did not want the participants to feel judged on any subject that we discussed as a feeling of judgment might have negatively affected their open conversation with me and their preparedness to share their experiences.

The participants were encouraged to ask questions before, during and after the interview. During the interview, some of them were upset or had emotional moments, so I offered to stop the recording. However, the participants stated that they could carry on speaking, so none of the interviews were interrupted.

Each interview was expected to last between 45 and 60 minutes. Most of them, however, lasted more than 60 minutes and some took nearly two hours. This was a positive result because the participants responded to the questions by describing their experiences and showed that they had developed a good rapport with me.

A short introduction was given to the participants before each interview to help them to feel comfortable, to develop a relationship with the researcher and to create a trusted environment. I briefly explained the purpose of the thesis and the participants read the Participant Information Sheet so that they were fully informed when they gave consent. I told them about the purpose and privacy of the audio recording and obtained their permission for it. Further details can be found in section 4.5.

4.3.4 Pilot interview

Before the interviews with the participants, I used the interview schedule with one of my PhD student peers who was using the same methodology (IPA) and others who were using an interview technique with the qualitative research method. They acted like participants and at the end of the session they gave me their feedback. In this way, I was able to refine my interviewing skills. For example, I gave attention to avoiding being critical while asking some questions. The pilot process also helped me see whether the thesis was in line with its purpose and objectives. My intention in conducting these practice interviews was to explore my approach as a researcher collecting qualitative data. After practising the interview schedule with my colleagues, I conducted the first interview with the first participant as a pilot interview in order to check the clarity of the questions and the length of the interview. This interview was included in the final sample because it went well and there was no change in the interview schedule. In the next section, I shall explain the data analysis process step by step.

4.4 Data Analysis

I followed the steps of IPA with each individual interview as recommended by Smith, Flowers and Larkin (2009) to analyse the data obtained through semi-structured interviews.

After each interview, I transferred my notes to my reflection diary (see Appendix 4.10) and I prepared for the next interview, thinking about how to improve the process and which points should be paid more attention. Notes were taken to ensure that important moments in the interview were not forgotten, and these were used in the analysis process. For example, some verbal and non-verbal interview notes were carefully recorded, along with many aspects of body language, such as the emotions expressed by the participant during the interview, any long pauses and any raised tone of voice.

In addition, after every interview, I tried to learn some new information from what the interviewee had said such as medicines and alternative medicines taken, television and radio programmes, facebook groups and various devices mentioned by the participant. In this way, if during a subsequent interview, these or similar issues were raised, I would be able to understand the participant better and sustain my communication with her a higher level (see Appendix 4.11). As an international student from Turkey studying in the UK for a PhD, I was not familiar with all of the things that the women talked about, so from time to time, I asked the participants to give examples or explain in detail what they had said. In addition, in order to have more detailed information and to understand the participants better, I tried to explore and learn from the points which I had difficulty understanding, or things which I heard for the first time in an interview. I shall discuss this issue in more detail in the reflectivity section.

I shall next describe the steps followed in the analysis.

Step 1: Immersion in the original data

I listened to each audio-recording in full at least four times during the transcription and checked my transcript for accuracy, grammar and anonymity. I was careful to understand and write the transcript correctly and the transcription process took about four months. The process of listening and editing continued throughout the data analysis and the audio-recordings were listened to over and over again.

In addition to recording their words in the transcripts, I recorded the participants' non-verbal emotions; eyes brimming with tears, crying, voice tremors, excitement, sadness, being happy, pauses, behaviour, facial expressions, tone of voice – soft, loud, angry, laughing, self-interruption and so on. In this way, I tried to reflect the progress of the interview in the most realistic way. Throughout the transcription process, I tried to clarify what was said by including explanations where necessary. An example is shown as Figure 4.2.

Figure 4. 2: The transcription process

- Helen:
... but he started having sex with other women when I was expecting my second child. So apparently that's quite common I think because some men don't like pregnant women.
- Explanation:
She seems very upset, so I wanted to talk to her and comfort her. Her eyes were filled with tears

I wrote out all the interviews verbatim and used transcript notation. For example, when the participant was emphasizing something, I put the text into bold. These notations enabled me to better recall and understand the content of the conversation. Other transcript notations were provided as an attachment (see Appendix 4.12). An example is shown as Figure 4.3.

Figure 4. 3: An example of transcript notations

- Angela:
As I suppose the sexual changes and menopause are that I want to have more sex now than I have done in the past, so I have more sex now than at any point in my entire life. So, the menopause has given me more of a sex drive . Which is partly [something] that's unusual (<i>laughs</i>).

In addition to the interview transcripts and the notes which I took during the interviews and afterwards, I researched many of the subjects mentioned by the participants and I kept this information in a separate Word file for each participant. For example, I obtained in-depth information about the participant by examining the data gathered on various subjects such as the purpose of an alternative medicine and how often it was used, information about the television programmes which the participant watched, information about the medicines used, the places where she obtained information, and the activities which she attended. This enabled me to gain a deeper understanding of the participants' experience and gain entry into their lifeworld (see Appendix 4.11). 'Lifeworld' is a term used to describe how the everyday experiences of individuals affect them (Tuffour, 2017). Throughout the transcription process, I only used the participants' pseudonyms.

After transcribing the first interview, I created a file for noting down exploratory comments in a column on the right, one for the transcripts in the middle and one for emergent themes on the left for later use. I printed off the three-column Word file and then, by analysing the text line by line, I wrote what I understood from what I read in the transcript on the right-hand side; this helped me to analyse the responses more fully and to better understand the participant.

In the first stage of analysis, I listened to the audio-recordings repeatedly while reading each individual interview transcript several times. This helped me to make a comprehensive analysis and enabled me to understand the emotions felt and to add my own contributions and comments. In addition, repeated reading allowed me to understand the general interview structure and how to analyse specific parts of the interview. From the beginning of the analysis, I had meetings with my supervisors. At these meetings, we read and analysed transcripts together. In addition, my supervisors gave me the opportunity to re-evaluate my comments about some participants. I was able to compare my analysis with the analyses made by my supervisors and to see the similarities and differences. In this way, I learned from experts what should be paid attention to while analysing responses. I also started to increase the power of my analysis and to see points which I had previously overlooked. Thanks to this, I continued the analysis more robustly in line with the feedback which I received from my supervisors. This worked as an interpretation check and helped to

identify that we were interpreting in the same way, and this helps to ensure reliability of data analysis (Ejegi-Memeh, Hinchliff, & Johnson, 2021).

Step 2: Initial noting

In the next stage of the analysis, I made line-by-line analyses and wrote my initial notes in the right-hand column of the transcript file.

This part of analysis was “the most detailed and time consuming” (Smith, Flowers, & Larkin, 2009; p.83). This process ensured detailed recording of the specific ways in which the interviewee understands, thinks about and talks about the subject. I avoided superficial notes and was careful to determine what was important to the participant. For example, these headings included questions, summary expressions and descriptive labels.

I made comments in the three categories of descriptive (D), linguistic (L) and conceptual/interpretative (C) suggested by Smith, Larkin and Flowers (2009); I used colours to differentiate these as shown in Figure 4.4.

Figure 4. 4: Exploratory comments

Transcript extract	Exploratory comments
- Angela:	
As I suppose the sexual changes and menopause are that I want to have more sex now than I have done in the past, so I have more sex now than at any point in my entire life. So, the menopause has given me more of a sex drive . Which is partly [something] that's unusual (<i>laughs</i>).	<p>L: More sex, Unusual</p> <p>D: She wants more sex than before</p> <p>C: Belief: the menopause increases her sex drive and having sex</p>

Furthermore, Smith, Flowers, and Larkin (2009) suggested that as you read particular words and phrases, you should write down everything that comes to mind and freely associate it with the text of the participant. I therefore wrote down some things even though they did not fall into a particular category. In addition to coloured pens, I used

D, L and C tags next to my comments. In this stage, as in every stage, my supervisors provided helpful feedback. An example is shown as Figure 4.5.

Figure 4. 5: Descriptive, linguistic and conceptual comments

Descriptive comments (the purple colour)	D: Comments which focused on explaining the subject of the speech text and the content of the participant's words.
Linguistic comments (the orange color)	L: Comments which focused on researching the specific use of language by the participant.
Conceptual comments (the turquoise color)	C: Comments which involved the researcher's evaluation of the participant's account at a more conceptual level

Step 3: Development of emergent themes

In the third step, I started to develop themes by looking at the notes which I had written rather than focusing on the transcripts. I added the resulting themes to the column on the left-hand side of the transcript file. An example is shown as Figure 4.6.

Figure 4. 6: Development of emergent themes

Emergent themes	Transcription extracts	Exploratory comments
	- Angela:	
Lack of professional support to inform menopause	The doctor hasn't mentioned about vaginal dryness. The doctor hasn't mentioned that; no one mentioned it. No one at the hospital when I had abdominal ablation mentioned it. Up to now no one has talked to me about the menopause symptoms. I have found out about the menopause symptoms and spoken to them.	D: Doctor has not mention vaginal dryness D: No one has talked to her about menopause symptoms C: Lack of professional support to inform menopause

	<p>So, because I know that I am going through the menopause. I went on the menopause cafe to know; I found other women that were going through it to start a discussion to talk.</p>	<p>D: Searching another support such as the Menopause Cafe L: No-one; She emphasised this</p>
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Although I tried to identify themes by focusing on the notes, I checked the transcript between the two columns again for any recall or decrease in meaning, which made me more confident about the themes which I had identified. In addition, in order to better understand some emotions, I often re-listened and checked the voice recordings while creating themes.

Step 4: Searching for connections across emergent themes

The aim of this stage was to bring together emergent themes which had been identified for a participant to construct a structure or map. To identify themes, I looked for patterns across the data, similarities and opposites. Themes which represented parallel or similar understandings and opposing themes were brought together. I opened a Word file for each theme and added to it the transcript(s) which contained the theme.

Step 5: Writing up the next interview

I applied the first four steps to each participant's transcript. It was important to deal with the next participant according to her own circumstances and to do justice according to her own individuality rather than simply carrying over the thoughts in the analysis which had emerged from the previous participant. Following this stage carefully is important for decreasing the possibility of bias.

Step 6: Looking for patterns across accounts

This stage involved searching for patterns among all the cases. I did this by laying out the general meanings on a large surface and looking for emergent themes across and

between the cases and for which themes were stronger. This led to restructuring and labeling.

Step 7: Developing superordinate themes and writing-up

In this stage, each participant had super- and subordinate themes individually because IPA requires individual deepening. This step involved combining the subordinate and superordinate themes of each participant.

For example, under sexual changes, which is a superordinate theme, I was able to reach the data of all participants about sexual desire by bringing together all the participants' conversations on this topic. In this way, comparing the views of all participants in the writing stage enabled me to see the similarities and differences more clearly. An example is presented in Appendix 4.13. I was also able to see which quotations were good examples of each subordinate theme for potential inclusion in the Findings chapter.

4.5 Ethical considerations

The University of Sheffield Research Ethics policy stresses the importance of maintaining the “dignity, rights, safety and well-being of human participants” in the conduct of any research study (University of Sheffield, 2012, p.6).

4.5.1 Ethical approval

Before starting the data collection, I submitted the required application for ethical approval to the School of Nursing and Midwifery Ethics Committee of Sheffield University with supporting documents (the participant information sheet and consent form) on 4 March 2019. I was asked to make corrections by the Ethics Committee and after making these, I re-submitted the request for ethical approval and I received ethical consent on 18 April 2019 (see Appendix 4.14). However, the ethics committee asked me to use an encrypted audio-recorder in order to protect the security of my work. I therefore made an addition to the ethics application on the advice of my supervisors and submitted a minor amendment form for the requirement of the designated audio-recorder on 2 May 2019 (see Appendix 4.15). Full ethical approval was then received from the School of Nursing and Midwifery, University of Sheffield

Ethics Committee (reference number 024455). After receiving this final confirmation, I started collecting data.

4.5.2 Participant Information Sheet and Consent Form

I gave the Participant Information Sheet to each participant before they agreed to participate in the thesis and I answered their questions (see Appendix 4.3). During the thesis process, I took care to protect the privacy and anonymity of the participants and I explained this to them in the confidentiality and anonymity section of the information sheet. The information sheet contained full details about the scope of the thesis, including the purpose of the thesis, the topics of the interview, risks, benefits, how the data would be collected and stored, and issues related to ethical considerations including informed consent and confidentiality. The information was written clearly so that the participants could easily understand it and make an informed decision about whether to participate.

At the beginning of each interview, two Consent Forms were given to the participant. They were advised of their right to refuse to answer any interview questions even though they had signed the Consent Form. In addition, they were assured that they were free to withdraw from the thesis without explanation during the interview or up to one month after the interview. One of the signed Consent Forms was then given to the participant and I kept the other copy securely in a private locked cupboard. The Consent Form is included as Appendix 4.4. If participants asked to know more about the subject, I sent them an email to give them more information.

Participants may find the topic difficult to talk about because it is a sensitive issue. Firstly, interviews were conducted in a private environment where participants can feel comfortable. During the interview, I asked general questions (e.g. about menopause in general) before moving onto questions about intimacy. Secondly, when I ask my questions, I used active listening and non-judgemental verbal and body language. Thirdly, I reminded at the beginning of the interview of their right to not answer questions they did not want to answer and they were able to ask questions at any point when they want. If any participant became tired or appeared to feel sad, I interrupted the interview for a while (for two participants) before asking the participant if she wanted to continue. Participants were offered a further in Information Sheet which I

had prepared which gave details of sources of support which they could contact if they needed more information and help (see Appendix 4.16).

4.5.3 Confidentiality and anonymity

The anonymity and confidentiality of the interviewees was maintained throughout. I completed the Protecting Research Data course at the University of Sheffield to learn how to ensure confidentiality and anonymity for my participants and how to protect the data obtained. To protect the confidentiality of the participants, only I and my supervisors had access to the recordings and transcripts. The real names and signatures of the participants were on the signed Consent Forms and these were securely filed and all the participants' personal information and other files relating to this thesis were securely stored in a locker in the PGR office at the University of Sheffield's School of Nursing and Midwifery; access was limited to me as the researcher and my supervisors.

Since the device used for the interviews was an eye reader and a special encryption system, its reliability was high. The records of the interviews were transferred to the my computer and onto the hard disk in an encrypted file.

While I was making the transcripts of the interviews, I took care to anonymize them; I used only the pseudonyms and removed any reference to identifiers such as name of partner, children and place of work in order to maintain anonymity. The data were stored in line with the requirements of the University and GDPR and the UK Data Protection Act 2018 (UREC, 2019).

4.5.4 Ethical framework

I explained how the ethical framework works with the following explanations.

Respect for autonomy: Respecting autonomy is largely accepting the opinions and choices of autonomous persons into consideration, and refraining from obstructing their actions as long as they do not overtly harm others (US Department of Health Education and Welfare, 1979). Besides, to respect autonomous representation means recognizing the existence of one's right to have an opinion, to make a choice, and to act according to one's values and beliefs (Beauchamp & Childress, 2012).

I sent the Participant Information Form and Consent Form days before participating in the study to the volunteers who wanted to participate in the study so that the participants could decide whether to participate or not. Detailed information about the study was presented in the forms, and these forms were made available to the volunteers days in advance. In this way, ample time was provided in the decision-making process of the volunteers, and a healthy process is allowed for the person to make a decision. This is explained in section 4.5.2.

I also tried to meet the requests and demands of the participants. For example, I went to the home of the participant who wanted to meet at home or to the workplace of the participant who wanted to meet at work. Sometimes, due to the change in their schedule, I rearranged the meeting date and time according to them, even if it was the last minute. During the research process, I tried to pay attention to the highest level of respect for the autonomy of the participants.

Non- Maleficence: Nonmaleficence is based on the Hippocratic "do no harm" principle and expresses the obligation to avoid or minimize harm. Some philosophers merge nonmaleficence and beneficence to form one principle (Beauchamp & Childress, 2012).

From the moment I contacted the participants, both before the study and during the interview, I gave importance to the thought that this study is a sensitive subject. For this reason, I explained to the participants that they have the right to not answer questions asked, and that they always have the right to not speak on the issues they do not want to. I also informed the participants that even if they participated in the study, they could leave the study within 1 month without giving any reason.

As explained in section 4.5.3, I explained to the participants the information that the data and documents of the participants will be kept securely. I explained that personally descriptive information will not be disclosed in this study and that their confidentiality will be taken into account. I told the participants that they could ask their questions about this subject.

Beneficence: Beneficence is not just about respecting people's decisions and protecting them from harm, but also acting ethically by making an effort to ensure their well-being (US Department of Health Education and Welfare, 1979) .

Although this thesis does not seem like a having direct benefit to the participants, it is possible that talking about issues that many people do not talk about makes them feel better individually. This was expressed by the participants during and after the interview. Thanks to the mutual exchange of some information, it can be said that the participants benefited.

Moreover, many participants stated that from the moment they heard about this study for the first time, it is important to research these issues and they would be happy to have any contribution. In addition, I explained to the participants that they would contribute to the literature thanks to their experiences and explanations.

Justice: The basic principle of justice in a research is equal treatment. This is actually a different expression of the principle of respect for the person. Injustice occurs when a person's rightful interest is deprived of that person without good reason (US Department of Health Education and Welfare, 1979).

The inclusion and exclusion criteria for participation in the study I predetermined and these criteria were taken into account in the selection of participants. Those who said that they volunteered for the study at first and then stopped participating in the study for any reason I welcomed with respect.

Summary of the Methods Chapter

In this chapter, I have explained in detail how I conducted the research process. I have described the sampling process, the recruitment of participants and the data analysis process step by step. Detailed information has been presented about the process for obtaining ethical consent and how all the participants were protected.

In the next chapter, I shall set out the findings from the acquired data.

CHAPTER 5: FINDINGS

Introduction

This chapter presents the analysis of the data. Verbatim interview extracts from the participants are used to justify and ensure understanding of the explanations of each superordinate and subordinate theme written throughout this chapter. After each quote, the participant's relationship status and age are given. In addition, explanatory texts and transcription notations such as **bold** type (when they emphasised something) have been added to the quotes of the participants in order to make the interview more understandable.

The findings were divided into five superordinate themes by bringing together the closest and most relevant ones throughout the analysis. Subthemes are also included to provide a detailed analysis within each of the superordinate themes. The five superordinate themes are: Sexual changes during the menopause (superordinate theme 1); Coping methods for sexual changes (superordinate theme 2); Menopause, men and relationship (superordinate theme 3); Managing menopause symptoms (superordinate theme 4); and The meaning, knowledge, talking about the menopause and the influence of the menopause on women's life (superordinate theme 5). Table 5.1 shows the all superordinate themes and subthemes.

Table 5. 1: Superordinate themes and subthemes

Superordinate themes	Subthemes
1. Sexual changes during the menopause	<ol style="list-style-type: none">1. Experiencing sexual desire (Superordinate theme 1: Subtheme 1)2. Avoiding intimacy and sex as a means of coping (Superordinate theme 1: Subtheme 2)3. Feelings about body image during the menopause (Superordinate theme 1: Subtheme 3)

	<ol style="list-style-type: none"> 4. Connection between the menopause and sexual changes (Superordinate theme 1: Subtheme 4) 5. Not experienced sexual changes since entering the menopause (Superordinate theme 1: Subtheme 5) 6. Sexual partner differences (Superordinate theme 1: Subtheme 6) 7. Considering sexual changes as a problem (Superordinate theme 1: Subtheme 7)
2. Coping methods for sexual changes	<ol style="list-style-type: none"> 1. Perception of medication and HRT (Superordinate theme 2: Subtheme 1) 2. Perceptions of alternative medicine(s) for sexual changes (Superordinate theme 2: Subtheme 2) 3. Other coping methods for sexual changes (Superordinate theme 2: Subtheme 3)
3. Menopause, men and relationship	<ol style="list-style-type: none"> 1. The perceived influence of the menopause on the personal relationship (Superordinate theme 3: Subtheme 1) 2. Feeling guilt and worry about the relationship (Superordinate theme 3: Subtheme 2) 3. Having a supportive or unsupportive partner (Superordinate theme 3: Subtheme 3) 4. Women's views on how men understand the menopause (Superordinate theme 3: Subtheme 4)
4. Managing menopause symptoms	<ol style="list-style-type: none"> 1. Perception, attitudes and knowledge about HRT (Superordinate theme 4: Subtheme 1) 2. Managing menopause symptoms by applying natural, sport, exercise and healthy food (Superordinate theme 4: Subtheme 2)

	<p>3. Managing menopause symptoms by applying alternative medicines, herbal tea and various products (Superordinate theme 4, Subtheme 3)</p>
<p>5. The meaning, knowledge, talking about the menopause and the influence of the menopause on women's life</p>	<p>1. The meaning of the menopause to the women (Superordinate theme 5: Subtheme 1)</p> <p>2. Pre-existing and current knowledge about the menopause (Superordinate theme 5: Subtheme 2)</p> <p>3. Talking about the menopause with friends, family members, healthcare providers, GPs and people from different circles (Superordinate theme 5: Subtheme 3)</p> <p>4. The impact of the menopause on other areas of women's life (Superordinate theme 5: Subtheme 4)</p>

5.1 Sexual changes during the menopause (Superordinate theme 1)

The analysis showed that participants in the menopause experienced many sexual changes. These changes and their effects on women are analysed generally under this theme. Some participants expressed their ideas about what sex meant to them. According to Gina, sex was not just satisfying one person but that both sides should benefit from it, and she emphasized that being in a partnership was more than just sex. She also stressed the idea that a woman having sexual intercourse to satisfy a man was a kind of abuse:

- **Gina:** *And sex is about a mutual benefit. So, you're doing it because you both want to do it. And if one of you doesn't want to do it, hasn't any interest in doing, it is not a pleasurable thing.*

- **Interviewer:** *Mm hmm.*

- **Gina:** *Why should that person do it because it is what this person wants to do*

to that person. If you're married or if you're in a partnership, the partnership is more than just sex, it's more than sex. And that ... I mean, I don't know whether I'm going to get my sex drive back. But to my mind a man should just masturbate and that's it. Because I think that it's ... how can it be? How can it be the right thing that the man is putting pressure on the woman to have sex just to satisfy his own needs? How can that be OK? It's a form of abuse, I think.

(Divorced, age 57)

Nancy stated that sex was a good time together and Linda said that sex was a “good escape”. The analysis showed that the participants thought that men and women should enjoy having sex together. In addition, as understood from women's discourses in other themes, although some participants saw sex as a duty, this analysis showed that others thought that it was wrong.

Seven subordinate themes were relevant to sexual changes during the menopause: Experiencing sexual desire; Avoiding intimacy and sex as a means of coping; Feelings about body image during the menopause; Connection between the menopause and sexual changes; Not experienced sexual changes since entering the menopause; Sexual partner differences; and Considering sexual changes as a problem.

5.1.1 Experiencing sexual desire (Superordinate theme 1: Subtheme 1)

This subtheme demonstrates the diversity of women's experiences of sexual desire because some experienced lowered sexual desire whereas others saw no change or experienced an increase. Furthermore, in the women who mentioned how long they had experienced a reduced sexual desire, the duration ranged from a short time to a few years. Further details are provided below which demonstrate the nuances within the women's accounts about sexual desire at the menopause and midlife.

Some participants considered that the menopause had had a negative impact on their sexual desire, and they believed that they experience low sexual desire due to menopause. In other words, according to them, there was a link between menopause and loss of sexual desire. As the next extract shows:

- **Belinda:** *I'm not feeling the same about sex as I did before the menopause, so that's had a big impact.*

(Married, age 49)

One participant said that her lack of sexual desire was not related to the menopause but that it was because of the poor quality of her relationship with her husband (now her ex-husband). The reason for this was clear in some of the words which she used. For example, she spoke about psychological violence: a “bad mood, bad temper, shouting, very controlling”, “it was emotional violence”, and about physical violence: “he did once [hit me] but he was just in a very bad mood all the time”; and about bad experience and the “bad relationship” from her ex-husband:

- **Interviewer:** *Did you feel any low sexual desire or something else?*

- **Helen:** *It was low sexual desire. But I do not think it was to do with the menopause. I think it was to do with him [ex-husband].*

(Divorced, age 60)

Eleven of the fourteen participants had experienced a decrease in sexual desire, which indicates that it is common during the menopause. These women said that it was due to a combination of the menopause and other factors, such as having a bad partner (like psychological violence, physical violence or cheating with other women. For some participants, the change had been significant and they spoke about it with emphasis:

- **Belinda:** *So, my sex drive has changed **completely**. I don't feel the same way about sexual relationships.*

(Married, age 49)

Interestingly, one participant who had a low sexual desire after the menopause stated that with this decrease, perhaps her sexual desire had reached a normal level because, in her view, she had had very high sexual desire before the menopause:

- **Camila:** *it's just not having that desire; you know ... something that's quite high anyway. ... I think for me it's probably easier because it [her sexual desire] was so high ... to start off with, but is probably now back to normal (laughs), to be honest. You know I'm being honest with you.*

(In a relationship, age 47)

In addition, loss of sexual desire had had emotional consequences such as feeling guilty and sad for some participants. For example, one participant who experienced loss of sexual desire emphasized a situation in which she felt guilty because her partner would think he had done something wrong so she did not want to have sex with him, rather than it was because of the menopause. So she stated that men do not understand this situation and therefore had difficulties:

- Dawn: The man doesn't really understand why you're saying no, no, no. And then, like I say, he thinks it's [because of] something he did wrong. No, it's not. It's just my body is not feeling like it. When I was a young woman and it was all, you know, I couldn't wait to be next to him, and then, and then it goes away.

(Divorced, age 56)

Similarly, another participant reported that her lack of interest in sex made her feel sad. She spoke slowly and her voice was quiet. Fiona's low tone of voice and facial expression clearly showed how upset she was about it:

*- Fiona: I think I'm just not as interested as I used to be in sex. And it's **sad**, really, in some way.*

(Married, age 64)

Also, some participants, like Angela, felt guilty and sad because they did not want sexual intercourse with their husbands or partners. Gina who had problems with her partner due to her lack of sexual desire talked about how difficult it was to have sexual intercourse. She also emphasized, like Dawn, that men do not understand why women experience low sexual desire:

*- Gina: I certainly suffer from it at the moment and I still do have a lack of **sexual drive and that, but it's difficult to explain.** I think that's ... I think it's something in itself. So that is a thing in itself. But on top of that you have, even if you don't want to have sex, you might still have some intimacy but even that is difficult also, but you can have different ways of having intimacy and uh, um ... I just think that men struggle to deal with women who have lost their sexual drive.*

(Divorced, age 57)

Unlike the women quoted above, Kath stated that she was single again and was not in a relationship; she was satisfied with this situation and was pleased with her life, unlike other participants who had experienced the loss of sexual desire. The implication of this is that the loss of sexual desire for some women is not always a problem:

*- **Kath:** OK. Yeah. Probably not. Not interested. I'm quite happy with the way my life is now, so I don't want anyone else to come in and interfere with that (laughs).*

(Divorced, age 56)

This view is critical for understanding the place of sexual desire within a relationship. Nancy stated that with her sudden loss of sexual desire, she tried to avoid sexual intercourse as much as possible until the demand from her husband was obvious. This can create deep stress and sadness for the women:

*- **Nancy:** So when I suddenly stopped feeling, erm ... first of all I didn't have the desire. I can go all day and all night and all day again without even thinking about it, unless my husband starts trying to get close ...*

(Married, age 59)

The following extract indicates that although many of the women had experienced decreased sexual desire, one participant's experience differed, and sometimes there was an increase in sexual desire. This shows that as well as individual differences in sexual desire at the menopause, sexual desire for each woman was fluid and changeable.

*- **Angela:** Erm ... I think now, for the past two months a decrease; before that, an increase.*

(In a relationship, age 51)

The following quotation illustrates that because of some menopausal symptoms such as vaginal dryness and brain fog, a participant might not want sex. Sexual desire can be affected by menopausal symptoms which are not specifically sexual:

*- **Interviewer:** What do you think caused the decrease?*

- **Angela:** *I think we go back to the vaginal dryness. Yeah. Sometimes, I don't feel like things are right down there and sometimes I feel like brain fog in my head and I can't think about anything other than this fog. I can't see through the fog in my mind to want to be intimate. Does that make sense?*

(In a relationship, age 51)

In addition, three of the fourteen participants stated that there was no change in their sexual desire and that sexual activity continued at the same level. Two participants (Linda and Mary) with this view had very low menopause symptoms and felt lucky, and Mary's husband had a supportive attitude, which might have had an impact on sexual desire:

- **Interviewer:** *... for example, did you feel any low sexual desires?*

- **Mary:** *No. No, nothing.*

- **Interviewer:** *You felt the same sexual desires?*

- **Mary:** *Yes. Yeah yeah definitely. Whereas some people don't.*

(Married, age 56)

Some participant used the term 'low libido' instead of reduced sexual desire. And some participants felt guilty for their low libido, like other participants who talked about feeling guilty because of their decreased sexual desire. When asked why this was, the participant emphasized that sex had been in her life for a long time and it was very difficult to think of a life without sex and that sex is very important for life. She also stated that despite being old, without sex life would be depressing:

- **Interviewer:** *Why did you feel sad?*

- **Julie:** *You know sex is good. Sex is a nice thing that I've been doing for a long time. I think that there is a kind of ... there's a kind of a bonding that happens around sex that is more than anything you can say to each other. It's a really important connection with somebody you love. But I think it is inextricably connected to that that feeling of being, being vital, being alive. I can't imagine not wanting to have sex even if I'm really old, But then I experienced the feeling of not wanting to have sex and it was really depressing. And it's kind of old.*

Then I just take some hormones and it's come back.

(Married, age 57)

This analysis shows once more that sex is important for women at all ages. Also, the widespread feeling of guilt indicates that the women see sex as a duty towards their partner or husband and therefore feel guilty when they cannot engage in sex. In summary, it is evident that sexual desire had been affected by the menopause and by other factors. In particular, this analysis has shown that decreased sexual desire is an important issue which needs to be understood by both women and men.

5.1.2 Avoiding intimacy and sex as a means of coping (Superordinate theme 1: Subtheme 2)

Six out of fourteen participants stated that they did not want to have sexual intercourse due to the loss of sexual desire. Some participants directly stated that the menopause had had an impact on their lack of intimacy. Indeed, some participants wanted to avoid sexual intercourse as a natural consequence of decreased sexual desire in the menopause:

*- **Angela:** I can't see a way to be intimate in my head ... I think, 'why don't you just leave me alone'. (laughs) Yeah, and then, and then I feel **really sad** because my partner is very loving and very caring and so he would ask if everything's OK. And then I say 'Well, this is how I'm feeling'. And then we would talk about it for a while and then sometimes what we do is, sometimes we will talk about the way that I'm feeling and then sometimes we'll talk about how the way that I'm feeling affects him. And then when I know that the way that I'm feeling is affecting him, something changes and it makes me love him more and then things are OK.*

(In a relationship, age 51)

For one participant, although she did not want sexual intercourse, she could not say no to her husband. She felt an obligation for intimacy towards her partner. This situation was described as a vicious circle by Fiona. In other words, if sexual intercourse is not desired, it will not be enjoyed and therefore it will not be desired next time. She implied that dyspareunia was another cause of low sexual desire.:

- **Fiona:** *I think he was tired, so he didn't try and be intimate as often, but no, I never sort of said no even if I didn't really feel in the mood. I was never sort of 'No'. But um because of the issues which I had, it was less comfortable so it was less enjoyable as well, which I think is a vicious circle in some ways because if you don't enjoy it, then you don't want to do it.*

(Married, age 64)

Much like Fiona, Julie admitted that she accepted intimacy only to satisfy her husband although she did not want sexual intercourse; she explained the emotions as follows:

- **Julie:** *I mean, I kind of tried to satisfy him but he knew my heart wasn't in it. And then after a while, I'd say 'You know, I just I don't I don't like this. You know it just feels like ... I don't like it'. And he was like 'OK, it's fine'. ... You know one of the worst things? This might sound silly, but one of the very worst things is we always used to, even if we weren't having sex, you know, we'd kind of cuddle up in bed, but then separate and go to sleep because I don't like being ... I move around a lot in bed so when he can't be called who would like to cuddle, [I said] 'Leave me alone, I'm going to sleep'. And then the kind of menopausal stuff starts to happen.*

(Married, age 57)

5.1.3 Feelings about body image during the menopause (Superordinate theme 1: Subtheme 3)

The participants were willing to talk about their feelings and thoughts about body image. All but one participant said that they had put on weight during the menopause and there were similarities and differences in their experiences of this. Analysis of their comments showed that weight had a significant reflection on their sexuality, body image and femininity. The participants stressed the importance of their weight within their sexual relationship and spoke of the opinion of men about weight gain.

If we take a deeper look at the women's views on this issue, the following issues emerge. First, It is possible to say that weight gain was seen as a symptom of the

menopause by some participants because some women gave weight gain in answer to the question about what the symptoms of the menopause are. The majority of the participants thought that gaining weight affected their body image and some emphasized that gaining weight was a very important issue for them:

- **Interviewer:** *Did your body image change?*

- **Camila:** *Oh, yes, I forgot to say, yes. Yes, that's ... a good important and very important (laughs). I've put on [weight] and for my entire life I've been really the same weight. I'm quite lucky. In the last year and a half, I put on... ooh how many kilos? Over 10 kilos.*

(In a relationship, age 47)

Weight status can therefore be seen as something which prevents women from feeling comfortable and confident. Mary clarified this by saying “I don't feel as comfortable as I did”, and Camila felt the same:

- **Camila:** *And so, yeah, that did affect me. Having said that, you know, I suppose [it's] the time in my life now. I'm quite confident, but if that had happened to me four years ago, I wouldn't be ... I wouldn't have been as confident, and it would have affected me a lot more really.*

(In a relationship, age 47)

For one participant, however, gaining weight was not considered a problem; she used the phrase “less hung up” about her body image, which implies that she did not worry too much about body image.

It can be understood from the data that body image is a subject which affects not only a woman but also her relationship with her husband or partner, that is, her sexual life. Elizabeth stated that weight gain had also affected her sexuality in a negative way:

- **Interviewer:** *How does it affect your sexuality?*

- **Elizabeth:** *Too terribly; badly, very badly.*

(In a relationship, age 58)

In contrast to Elizabeth, Mary and Belinda stated that despite her weight gain, her sexual relationship was not affected:

- **Interviewer:** Do you think that weight gain affected your sexuality or sexual relationships?

- **Mary:** No, I don't think so. No, we've got [a] very good [relationship]. We talk an awful lot about how we feel. So, I think I'm pretty lucky that ... , you know, whereas I know a lot people who just, you know, you mention the 'M' word [menopause] and they run a mile. You know, ... 'I don't want to talk about that'. But [husband's name] is very good with things like that.

(Married, age 56)

Some participants mentioned that their husband or partner had made unfavourable comments which affected them deeply. Elizabeth said sadly that her husband did not like her being 'fat'. One participant, Helen, said that she had the hardest time over this subject. She said that her ex-husband had considered her gaining weight a major problem and had put pressure on her to lose weight, and he also compared her with other women. Specifically, Helen emphasized his use of an 'unfavourable' word and was incredibly upset when she said it during the interview. She also said that her husband was not polite at all. Believing that her weight had affected her husband's decision to leave her, Helen revealed that she felt guilty for not losing weight:

- **Helen:** I think he, and also I, put on weight and he didn't like that.

- **Interviewer:** What did he say to you and why do you think putting on weight [was a] problem?

- **Helen:** He made constant references to how fat I was. And, yeah, just constantly making references, but I think he was already seeing other women at that point. So sorry. He would have been comparing me **unfavourably** to other women. Erm ... Well he would compare me: 'Oh, so-and-so isn't fat like you' – that type of thing. But at that point, I didn't know he was having an affair with those people. It was when I found out he was having an affair, well it had been quite a few affairs. And then the last one, I had just had enough. So I asked him to go. Not quite as politely as that.

(Divorced, age 60)

On the other hand, the partner or husband of five participants had a positive perspective on this situation. Some men were happy with their partner's body and although they did make some jokes, they used light humour:

- **Interviewer:** *He knew you before the menopause; did he say anything about your body or not?*

- **Belinda:** *No. I think, I think mostly he's, erm ... he's rarely happy with what I look like, erm ... and he'll ... sometimes make inappropriate jokes about being fat because he thinks he's funny but then I make jokes about him getting fat because we're both pudgy and middle-aged. So I think that's his sense of humour, but it's not very often; and he erm...yeah he'll remind me that when we first met, erm ... I wasn't that slim but I wasn't as fat as I am now, so to me it feels like quite a big difference to him, he's a bit, you know, [likes a] few lumps and bumps. He's not really bothered. So, I think he's really quite positive.*

(Married, age 49)

- **Isabel:** *He just laughs. Well, he'll just say, you know, 'You're looking a bit fat today' or 'Where's that tummy come from'. It just makes it funny.*

(Married, age 49)

Camila similarly stated that her partner did not have any negative reactions to her weight gain during the menopause, and they talked about weight and that the weight did not create a problem for their relationship. Only during this conversation, she said with a laugh that her partner was a "quite big" person, so the fact that her partner was quite big may have influenced the fact that Camila's menopausal weight was not a problem for her partner.

Unlike other participants, Gina was told by her partner that he did not want her to lose weight because he liked her backside, but while she was talking about this, she was very shy and expressed the belief that men like women's bottoms:

- **Interviewer:** *Did your partner say anything about your body image?*

- **Gina:** *No, not really. Not really. I mean, I think he noticed that I put on weight and when I lost weight, I think he was almost disappointed.*

- **Interviewer:** *Why?*

- **Gina:** *Because (she breathed deeply) he liked the shape of my backside. And then when I lost weight, he thought my body shape was changing in a negative way. So, I think, as you know, older women often don't have much bottom and men like women with a bottom.*

(Divorced, age 57)

For five participants in particular, gaining weight made them feel less sexy, less like a woman and less sexually attractive. Some participants believed that men found slimmer women more attractive. If we look at the accounts of the participants in more detail, we can see that Elizabeth stated very clearly that “I did not feel feminine any more”. Similarly, Isabel felt less sexy after gaining weight because of feeling “uncomfortable”. She said that the main reason she felt uncomfortable was because “there are too many lumps and bumps”.

When I asked Kath if she felt the same sexual attraction after the menopause or not, she said that she could not feel the same sexual attraction because of gaining weight, which had caused her to lose confidence. When I asked her to explain this a little more, she said that she did not think that anyone would find her attractive if she is overweight and she preferred “bigger, baggy clothes” to hide to her weight and she felt “less fashionable” inside these clothes. Furthermore, as the next excerpt illustrates, Dawn also said that she did not feel the same sexual attractiveness. She also said that she did not want to be without clothes:

- **Interviewer:** *Did you feel the same sexual attractiveness?*

- **Dawn:** *No, not really. Because you want everything to be like [it was when you were] young ... But when I was younger, my body [was thinner]. But then you think ‘Oh, my stomach's fat!’ and I don't want to be without clothes because he won't think I'm attractive ...*

(Divorced, age 56)

Helen explained the change in the female body due to weight gain by giving an example that a woman is seen as less sexy; and her ex-husband “found slimmer women are more attractive or attractive”, adding “So it's a bit shallow, isn't it”. On this issue, the analysis identified that some participants had established a strong

association between weight gain and a change in body shape, as well as decreased sexual attractiveness.

Another important finding is that the perception of weight status in society made some participants felt less desirable. This highlights the way that women equated a slim body with sexual attractiveness for white women in the western world, particularly when these women were growing up:

*- **Interviewer:** Do you think that putting on weight affected your relationship with your husband or your sexual life?*

*- **Julie:** I don't think he cared. But, you know, in the way that I've told you that because I am in society and I'm constantly seeing these images of what makes a desirable woman ... and if you're overweight you feel less desirable. So, I did not feel good about that.*

(Married, age 57)

It was clear from the analysis that the participants needed to change the type of clothes that they wore because of gaining weight. In particular, Julie used the term 'mutton dressed as lamb' and thought that she needed to change her outfit.

*- **Belinda:** I have boxes of clothes packed away which are different sizes which I've never had before. I've always had a relatively stable shape, so it's been frustrating. I may be less so about body image because I'm trying not to get too wrapped up in that, erm ... in what shape women should be. Obviously, we all have an idea of what we'd like to look like ...*

(Married, age 49)

*- **Julie:** I can't wear those things anymore. I can't walk into a shop and find something nice. I could walk into a shop and find stuff, that is, stuff which either looks like it's for an old lady ... It's all navy blue or voluminous, you know, scarves or things that disguise the body or things that are for young women, so I try them on [to see if] they fit and they show every lump on my body that on some level I think I shouldn't have.*

(Married, age 57)

The participants had used various ways to lose weight. This will be discussed later in the section on managing menopausal symptoms.

The only participant who stated that there had been no weight gain said that she saw different issues about body image as a problem and wanted to change them. Describing her experience at a hairdresser's about her hair going grey, Linda emphasized that she wanted to look more attractive by changing her appearance:

*- Linda: So, it doesn't feel an issue at the moment, but, you know, I don't know, maybe in five years' time obviously, you know, I'd like to have less lines [wrinkles] and grey, you know. But I went to the hairdresser to have some colour put in. I went to make an appointment and then when I went back to have it done, it was the same man who I made the appointment with who was doing it. He said. 'The people, I don't know if they were all women, but anyway [the people] who were in when you came in to make the appointment ... he said 'Why, you know gray hair is **fashionable** at the moment'. So, they were like, they liked my gray hair. ... I think the other customers said "Why?" when I went out; they said 'Why does she want to have her hair done? She looks good already'. So he told me that when I came in so that I could have colour put in because I thought it would make me look a bit younger maybe. And so, he told me that. So, then I only had a little bit of it [the colour] (laughs). I don't know. Yeah, I wanted a little bit. Anyway, I'm going to have some more. This is, like, four months ago, so it's a long time since I had it done. But gray, I don't know if you've seen it but gray is a bit fashionable now. Some people are putting [gray] in you know. So yeah, I don't want to be completely gray; I guess it's about how you interact with people really. The whole attraction thing. I don't think you need to look **really, really young**, [to have] that perfect look to be attractive.*

(Married, age 56)

5.1.4 Connection between the menopause and sexual changes (Superordinate theme 1: Subtheme 4)

Over half of the participants (eight of the fourteen) talked about the relationship between the menopause and sexual changes and they all agreed that there is a link

between them. They used words which support the view that these changes are highly related to the menopause, such as 'definitely', 'mostly' and 'a lot'. Some participants said that they did not know why and others thought that it was related to physical changes such as oestrogen levels declining, gynaecological changes and psychological factors, as will be demonstrated in the following extracts.

- **Interviewer:** *Do you think that there is any relation between the menopause and these sexual changes? That it is related to the menopause?*

- **Belinda:** *Feels like it, feels like it's related. Erm... it feels like it's kind of happened at a similar time. Erm ... and I think when I've read about the menopause there's been talk about people's sex drive being impacted, people's libido, people's urges to – you know ... changing. So, it definitely feels like it's related.*

(Married, age 49)

In this excerpt, Belinda openly expressed her opinion that the menopause affects the libido in sexuality and therefore the relationship between the menopause and sexual changes is definite. Nancy stated that the cause of sexual changes in the menopause may be the hormonal decline experienced during the menopause:

- **Nancy:** *Erm... I think, yeah, I think, I'm sure it's the drop in hormones that makes a difference. And also, the way you've just, the way you feel about yourself, if you don't feel good about yourself anyway.*

(Married, age 59)

Furthermore, Elizabeth expressed the view that gynaecological changes occur and the fact that each woman's menopause experience is different, which she likened to our fingerprints, might also play a role in these changes. The factors which affect the menopause according to Elizabeth are shown in the next extract:

- **Interviewer:** *Do you think that there is any relation between the menopause and sexual changes?*

- **Elizabeth:** *Actually, we say yes. There are a lot because there are many gynaecological changes; my sister had prolapsed womb and that was connected to her menopause and the hysterectomy which she had to have. And*

there are also sort of other gynaecological changes, particularly if you've had children, which that can affect women in the menopause. But for each woman it's different. No two women have the same menopause. It's as unique as your fingerprint because what I've learned is that there are four main things that affect your menopause, your lifestyle your medical history, your diet and your genes, and they all have an impact on your menopause.

(In a relationship, age 58)

This analysis is also important in terms of supporting the opinion expressed throughout the thesis that every woman's menopause is individual and that individual differences should be taken into account. In addition, ageing was perceived as another factor as well as the effect of the menopause on sexual change, as the next extract shows:

*- **Interviewer:** Do you think this changing is related to the menopause or not?*

*- **Julie:** I think the menopause compounds ageing. You know, the things that happen around the menopause are so drastic, or at least they were for me. You seem to lose a lot quite quickly. And for me, when my symptoms became much worse, the loss of physical strength and libido went together.*

(Married, age 57)

The fact that the severe symptoms of the menopause caused Julie to lose her physical strength and that she said that her libido went with it points to the connection between menopausal symptoms and the sexual change experienced in the menopause in this analysis.

*- **Nancy:** What's happened to me [sexual changes] has been definitely, **definitely, now I'm sure it's definitely** related to the menopause. But then it's ageing, it's natural ageing as well. Don't, don't you think? Yeah, I think it's a natural thing and I think it's to do with sort of ageing as well. And, uh, and life because you don't know when you're younger. You don't have as much - as I was talking about before – sex and intimacy. (laughs)*

(Married, age 59)

In this quotation, Nancy gave one of the clearest explanations of this subject and she believed that the effect of the menopause on the sexual changes which she

experienced was definite, but she also stated that ageing, as Julie had said, had an effect on this process as well as the menopause. It is important that a second participant who talked about this issue drew attention to another point. According to Angela, the sexual change during her menopause was an increased sexual desire, so the same participant who had stated that the menopause had caused an increase in sexual desire in the previous theme explained this in different way in another comment and thought that this situation is slightly unusual:

*- **Angela:** I suppose the the sexual changes and the menopause are that I want to have more sex now than I have done in the past, so I have more sex now than at any point in my entire life. So, the menopause has given me more of a sex drive. Which is partly [something] that's unusual. (laughs)*

(In a relationship, age 51)

One participant said that she had had a vaginal prolapse and that that condition had affected her sexual life. She considered that she would feel as if she was hurt or weird because of the vaginal prolapse problem. This analysis showed that the women's gynaecological problems had an impact on their sexual life.

*- **Interviewer:** You have had vaginal prolapse; has it affected your sexual life?*
*- **Julie:** Oh. you mean was I affected by it because I was worried that it would hurt or, you know, something weird would happen or that it would feel weird to ... It's fine, fine.*

(Married, age 57)

This analysis showed that most of the participants believed that sexual changes were associated with the menopause, but did not rule out the influence of other factors such as ageing and gynaecological changes.

5.1.5 Not experienced sexual changes since entering the menopause (Superordinate theme 1: Subtheme 5)

Three participants stated that there had been no change in any aspect of their sexual life since entering the menopause. The remarkable point here is that I thought that they might have spoken about experiencing a different sexual change during the interview, because these three women stated that they did not experience any signs

of sexual desire, as was noticed in the previous themes; so I asked them this question: "Have you experienced any sexual changes since entering the menopause?" Their answers reinforced what they had said at the beginning of the meeting. In the next quotation, Mary stated that she thought that she was lucky because there had been no change in herself after she had heard about the sexual changes that people experienced after the menopause. It can be said that this thought actually shows that sexual changes were seen negatively in these women's lives:

- **Interviewer:** *Did you see any sexual changes after the menopause?*

- **Mary:** *No. No. That's why I said I've been very, very lucky, and I appreciate that. So when, you know, when you hear some some people, maybe you've got the wrong person to talk to (laughs).*

(Married, age 56)

It is noteworthy that one participant had a situation different from other participants, which was that her husband had no sexual desire. Linda emphasized that the real problem was her husband's sexual difficulty. She frequently mentioned that she did not experience decreased sexual desire despite her husband's lack of libido. This will be explored in more detail under the following superordinate theme ('Menopause, men and relationship'):

- **Linda:** *I think it was difficult with my husband not being interested [in sex] but now it's important to me in a rush today, but to feel good about how you look to have interactions with other people. Um, you know a bit of flirting or, you know, a bit of attraction. Um, and I have some friends who have said positive things about me. So yeah, I feel like it is important to feel attractive still. And I have friends who have told me that I am attractive and that feels really good.*

(Married, age 56)

5.1.6 Sexual partner differences (Superordinate theme 1: Subtheme 6)

Angela said that she had had relationships with women before the menopause but that after the menopause, her desire for her sexual partner has changed, and that the

menopause had affected her sexual preference. She stated that she had accepted this situation but did not know why it had happened. When asked whether the situation was caused by hormonal change, she again said that she did not know why it had happened. Interestingly, however, Angela stated that there is no risk of getting pregnant in the menopause, which could have been why she may have wanted to establish a relationship with a man:

*- **Angela:** My current partner. So, I have two children but in between [having] those children, my relationships were with women. So, when I met my male partner, that would be my change of sexual desire. I wanted a male partner. And I'm 51 now. So, in 30 years I have only had a male partner for five of those. So, I did not find I wanted to have a relationship with a man. And so, my desire changed. ... My sexuality changed. ... Yeah. So, before I wanted a girlfriend and now, I want a boyfriend ..*

*- **Interviewer:** You mean that the menopause affects your change in sexuality?*

*- **Angela:** Yeah.*

(In a relationship, age 51)

Another participant had experienced a change like Angela but she was different in terms of the direction of the change of her sexual partners from male to female, and she said that she was now interested in women, not men. When speaking of her problems with her ex-husband, Helen said directly that she was more willing to have a relationship with women without any question. When asked why this change had occurred, she said that perhaps her bad experiences and her husband's constant bad mood might have had an impact on this change:

*- **Interviewer:** Even if you knew about this problem, you continued your married life?*

*- **Helen:** Yes, because I thought that's what I had to do. But something else I haven't said which I'll say now is that now, if I was to have another relationship which I don't think I'm not sure about, I'd be more interested in having a relationship with a woman than a man. I feel more sexually attracted to other women, but I don't know how much that is because I'm not too keen on men, if you know what I mean.*

*- **Interviewer:** You don't want to have a boyfriend?*

- **Helen:** No. Well, sometimes, I think. I do have friends who are men, but I'm not attracted to them. I don't want them in the house.

- **Interviewer:** You don't want to be with men?

(Divorced, age 60)

Although her case was not exactly like the other participants, Linda stated that she had had a relationship with women in the past and that she enjoyed having sex with both men and women. When asked why she had such a preference, she said that sexuality is a spectrum. According to her, many people in the community are bisexual, but people expect you to be either gay or heterosexual in society:

- **Linda:** Yes. OK. I mean I don't know how it relates to the menopause, but I can talk [about it] anyway. So, I'm bisexual anyway, so I've had relationships with women as well as men. So I like to be sexual with women as well as men. So in the past, I have had sexual relations with women too. But since I've been with my husband, I've not been sexual with anybody else except him for 40 years. So, I don't know. Yeah. I like sex, I like to play, you know, have fun, try out different things.

- **Interviewer:** Sorry. You said that in your past life you have had relationships with women?

- **Linda:** Yes. So that could be a solution.

- **Interviewer:** Why do you choose it?

- **Linda:** Why? Mm hmm. Well, I actually think, umm, I think sexuality is a spectrum and I think lots of people are bisexual really but, in this society, you're supposed to be either gay or straight, you understand? Homosexual or heterosexual. But actually, I think it's a spectrum and there're lots of people in between. So, I'm kind of in between. I don't know, maybe I'm quite easy-going so my mind's not too stuck on things. I don't know. But also, in the 80s when I was first having relationships with women, it was quite a political thing, a feminist thing. So you don't need to have relationships with men, you know. So, it was partly a feminist thing at the time. I feel quite open and relaxed with my sexuality.

(Married, age 56)

When asked why she needed a boyfriend instead of a girlfriend, Linda said that it was easier to find a boyfriend than a girlfriend. However, she said that it is difficult to maintain a relationship with a man and that many people have problems with men:

- **Interviewer:** *Yeah, I understand. I would like to learn. For example, if you have girlfriends after that, how did you decide to have a boyfriend? Why do you need a boyfriend?*

- **Linda:** *(4) I'm trying to think of the answer why. Well, it's easier to find a boyfriend than a girlfriend because there are more men looking for a woman than there are women looking for a woman, so then that's easier. And at the time, I thought yeah, when I had my daughter, so I was on my own when I had my daughter.*

(Married, age 56)

Linda also explained that establishing relationships with women was not as easy as she thought at first. Linda's comments are important for the analysis because they allow us to see the perspective of a bisexual woman:

- **Interviewer:** *Do you think a male relationship is easier than female relationships?*

- **Linda:** *No, no, no; not necessarily. No. I think when I started the female relationships, I thought that was easier. But I don't think it is. No, but lots of people have problems with men.*

(Married, age 56)

This analysis suggests that women's sexual preferences can change because of the menopause or for other reasons. In addition, the analysis shows the need to consider these changes in menopausal women.

5.1.7 Considering sexual changes as a problem (Superordinate theme 1: Subtheme 7)

Nine participants expressed their opinions about whether sexual changes are a sexual problem or not. The analysis illustrated that there were various perspectives on this subject. The majority of the participants believed that sexual changes would be a problem, but they were reluctant to give enough explanation as to why they believed this. For instance, Camila believed that sexual changes could be a problem and that a

hormone deficiency could be the reason, as the next excerpt demonstrates:

- **Interviewer:** *Do you consider the changing to be a sexual problem?*

- **Camila:** *I think it could be. Yeah. And because of that, you know, the lack of hormones, and that could cause a problem. Definitely. Yeah.*

(In a relationship, age 47)

Like Camila, Fiona also stated that she saw sexual changes as a problem. Fiona said that, very different from her youth, apart from being spontaneous and fun, sex had turned into a more planned and thoughtful action, as the next excerpt demonstrates:

- **Interviewer:** *Do you consider the changes, you mentioned sexual desire, vaginal dryness and less libido, to be a sexual problem?*

- **Fiona:** *I mean it is, in that, yeah, it means it means you have to think more about when you're actually going to have sex rather than just be spontaneous and fun like it was when you were younger.*

(Married, age 64)

On the other hand, two participants did not consider sexual changes to be a problem. The following excerpts show that the important issue at this point was that the spouses understood each other and that it would not be a problem when talking to each other. It was underlined that it was important how people saw sex and that it is not only sexual intercourse but also physical intimacy such as touches or hugging:

- **Interviewer:** *I would like to learn your opinion again; do you consider the change(s) to be a sexual problem?*

- **Nancy:** *No, I don't. I don't think it's a sexual problem. It's just something ... it's only a sexual problem when one person doesn't understand, so it has been a problem, but I think at the moment it's, it's difficult because it can be a sexual problem. Because it's like something that's happening in my body that's not working properly any more. So I suppose it could be a sexual problem but there are ways you can [get over it] if you talk to your partner. There are ways you can get through and ... um I suppose it's, uh, it's how you look at sex, isn't it? Whether it's just a mechanical – you do it or you don't do it. There's lots of things*

in between, like just being close to someone, being able to just, just, just be close and ...

- Interviewer: *Hugging and kissing. Not only intimacy?*

- Nancy: *Yeah. Yeah. And just letting somebody know that you care about them. But I think that it is affected a lot by the menopause because, take myself, I don't [do it] anymore, not so much, but at the time I was pulling myself away from him to avoid it, whereas he was feeling, like, I don't care about him anymore, so it's sort of making sure that you are still close. It's hard though, it is hard to be close when, you know, when you're in close, in that space where ... yeah. (laughs)*

(Married, age 59)

Angela also stated that she could understand why she did not want to have sex due to menopausal problems such as heavy bleeding and that she would want sex if she did not bleed. This analysis revealed that the two women knew why the sexual changes were caused and this made them not view sexual changes as a problem, as the next extract indicates:

- Angela: *When I was bleeding there [vaginally], I did not want to have sex. So it wasn't, ... it was the bleeding that was a problem and not the sex. If I wasn't bleeding, I may have wanted to have sex but I was bleeding because of the menopause. So, I don't know, and now I'm not bleeding. I want to have sex. So is that because I am not bleeding or because of the menopause? I don't know, I don't know.*

(In a relationship, age 51)

Unlike the other participants, Linda stated that her husband's sexual desire was low, and she answered this question by considering her husband's condition and accordingly reported that it was her husband who had a sexual problem. This analysis highlighted that there are no sexual changes and sexual problems only for reasons related to women, as the next excerpt demonstrates:

- Interviewer: *Do you consider your husband's sexual changes to be a sexual problem?*

- **Linda:** *His sexual problem or my sexual problem?*

- **Interviewer:** *Both. First of all, for him.*

- **Linda:** *He's got a sexual problem, yes, and it is a problem for me.*

(Married, age 56)

The next extract shows that some of the participants had difficulty in clearly answering 'yes' or 'no'. However, the idea that this was due to particular factors prevailed. First, there was the belief that individual differences and relational differences were important in seeing sexual changes as a problem or not. For instance, if there was previously a very active sex life, it would be a problem to cut it suddenly. This analysis has shown that different views on this subject can change depending on many different factors, as the next excerpt shows:

- **Interviewer:** *I would like to learn; do you consider the changes to be a sexual problem?*

- **Belinda:** *Waww, that's a good question. (4) I don't know. That's interesting. I'm not entirely sure, it could be. It feels like an interpersonal problem, a kind of a relationship because it is an issue and it is something ... I think I've got a good relationship but it is an issue and it does cause problems; even when negotiating the space it does cause problems But yeeeah, maybe.*

(Married, age 49)

Kath also emphasized that the understanding of the partner and mutual dialogue on this issue are important, which was mentioned in a later superordinate theme: 'Menopause, men and relationship'. The next excerpt shows this:

- **Interviewer:** *You have a lot of conversations with women. Do you think these women's sexual changes to be a sexual problem? What do you think about that?*

- **Kath:** *Well, it depends on what the sex life was before. If this suddenly ... if she was very active, then all of a sudden, there's no interest, it obviously would cause relationship problems also especially if the husbands don't understand the partner's state, understand why they feel that way. So that's why I think there needs to be, like, a lot more conversations about it because now there's a lot more to say, like the menopause cafes and a lot more online as well about*

it. So, I think that conversation is the most important part of it.

(Divorced, age 56)

Summary of superordinate theme 1

In summary, this first superordinate theme has shown that especially for menopausal reasons, the participants faced many emotional and physical changes and problems in their sexual lives. The analysis has shown that decreased sexual desire was seen as one of the most prominent sexual changes for many participants. In addition, the analysis showed that it is possible not to experience any decrease in the level of sexual desire or even to experience an increase in the level of sexual desire.

The analysis illustrated that there was a decrease in the frequency of sexual intercourse depending on the sexual changes and other factors mentioned in the first superordinate theme. Furthermore, the analysis showed that avoidance of sexual intercourse also occurred in some situations. One of the topics most frequently expressed by the participants was weight gain and the change in their bodies, as well as the fact that they felt less sexually attractive due to the menopause as well as age and various other factors, and this analysis revealed the impact of this on sexuality and on the woman's feeling of femininity. Moreover, the analysis revealed a strong link between the sexual changes experienced by the participants and the menopause. In addition, from the analysis of the statements, some remarkable participants also emerged. After the menopause, one participant had made a change in the gender of her sexual partner. Finally, as a result of the analysis, we can say that this superordinate theme underlines the fact that most of the participants saw sexual changes as a problem and that sexual changes in the menopause should be addressed for women.

5.2 Coping methods for sexual changes (Superordinate theme 2)

Following the previous superordinate theme, how the participants coped with sexual changes and the solutions which they developed to cope with them constitute this second theme. These coping methods are presented as three subordinate themes: Perception of medication and HRT; Perceptions of alternative medicine for sexual changes; and Other coping methods for sexual changes.

5.2.1 Perception of medication and HRT (Superordinate theme 2: Subtheme 1)

None of the participants had used medication to help to solve their sexual changes. They tended to exhibit a negative attitude towards using medicines in general. According to some participants, medicine should be the last option. The perception of the participants towards medication use were analysed in depth under the superordinate theme of managing menopause symptoms.

Three participants (Camila, Julie and Nancy) had used HRT to deal with their sexual changes, but they started using HRT due to hot flushes and similar physical symptoms. In other words, they did not directly apply HRT for their sexual changes, so this issue was also analysed in depth under the theme of managing menopause symptoms, as the next excerpt illustrates:

- Julie: ...I genuinely feel like taking the HRT meant that a lot of those problems have gone away. I'm very apprehensive about what's going to happen when I stop taking the HRT but I just, you know, because the HRT has given me back those feelings of strength and libido in many ways, I don't feel that menopausal, you know, because, because the er ... when I had the strange symptoms, because was so bad. I know the fact that I wasn't having sex was the least of my problems at that point.

(Married, age 57)

5.2.2 Perceptions of alternative medicine for sexual changes (Superordinate theme 2: Subtheme 2)

It was mentioned in the sexual desire subtheme that all eleven participants who stated that they had experienced sexual changes (such as low sexual desire) said that they did not use any medication for this. The analysis shows that similar to the previous subtheme, ten of the participants did not use an alternative medicine for dealing with sexual changes. Only one participant who had a decrease in sexual desire stated that she had benefited from Maca powder as an alternative medicine for this issue. Gina explained:

- **Interviewer:** *You said that you feel a loss of sexual desire. Have you done anything to overcome these changes? Did you do anything to increase your sexual desire?*

- **Gina:** *Maca powder helped with that.*

- **Interviewer:** *Did it affect your sexual desire?*

- **Gina:** *Yeah, it does. You need to look it up. I think.*

(Divorced, age 57)

On the other hand, it is worth noting that the analysis showed that many participants had used alternative medicine(s) for the physical symptoms of the menopause. Therefore, alternative medicines generally used by the participants for menopausal symptoms are analysed within the superordinate theme of managing menopause symptoms.

5.2.3 Other coping methods for sexual changes (Superordinate theme 2: Subtheme 3)

Apart from medication and alternative medicine, four participants had tried to overcome their changes and difficulties in different ways. One participant said that to increase her sexual desire, she had engaged in activities such as pelvic exercises, eating well, staying fit, cutting her hair to change her appearance and wearing beautiful dresses. She also stated that if somebody desires her, it activates her own sexual desire:

- **Interviewer:** *Have you done anything to overcome these changes and difficulties? For example, for sexual desire, did you do anything to increase your sexual desire?*

- **Angela:** *What I did do was pelvic floor exercises. I try to keep fit because if you eat well and you move more, you are more likely to feel better and then want to have sex. So, I don't do anything more than that; so I eat well, I move more I have my hair cut, you know, I would buy myself something [like a] nice dress so I feel better. If I feel like I look good and my partner tells me that*

I look good, I feel like I would want to have sex more. When somebody desires me, that makes me feel desire.

- Interviewer: *His behaviour leads you to increase your sexual desire.*

- Angela: *Yeah, yeah.*

(In a relationship, age 51)

Belinda had thought that she had to do something about this subject for a long time and was critical of herself on this subject, but she felt that it was not such a big thing and that she should just cope with it. Contrary to her own opinion, when she was asked more in-depth questions, she said that she was considering getting medical help for the lack of sexual desire:

- Interviewer: *You only talked with your partner, OK? Did you do anything to solve it? For example, to increase your sexual desire?*

- Belinda: *No. I think, erm ... puff ... I think it's, erm ... something I've spent quite a lot of time thinking about and, erm ... I think ... that I've been actively doing something but I've been thinking about how I feel and probably being quite critical of myself and I've been thinking, erm ... because maybe when you've been in a long-term relationship with someone for a long time, it didn't feel like such a big thing to just cope with just, you know, just have sex even if you're not that bothered. It's, you know, it's about compromise. But actually, I think there's been times when I felt ...*

- Interviewer: *Only thinking?*

- Belinda: *Yeah.*

- Interviewer: *What did you think?*

- Belinda: *I think it's, um ... it's interesting because as you say, there's a bit of me thinking well maybe I ought to look and think about getting something, but to be perfectly honest I don't think it's really ... I've really thought about getting medical help for that. That just feels like a change in how I look at the world. It doesn't feel like I'm not considering getting kind of medical help with that.*

(Married, age 49)

Dawn stated that she thought “wonderful things” to deal with her sexual changes. She

did not explain what she meant by this but we can speculate that it meant sexual fantasies. She also noted that orgasm was delayed due to changes in the body on both sides. The implication of this is that a man's body is important for women to reach orgasm:

- Dawn: Just wonderful things. When you were young and when you first met, and, you know, I mean, his body didn't change anyway so he still had a beautiful body, so I didn't really have to work too hard. I think about it, but just two bodies seem to be slower in getting to an orgasm.

(Divorced, age 56)

Helen, who was under significant pressure from her husband because of her weight gain, said that she was trying to lose weight and carried on doing her makeup. Even so, she said that she could not please her husband and that he had begun to have affairs when she was in her 30s:

- Helen: I did try to lose weight. I sometimes tried to put makeup on and stuff, but whatever I did never pleased him even in the younger days. So, you know, he started having affairs when he was ... when we were both 36. So that was quite a lot of years of having affairs.

(Divorced, age 60)

In general, the analysis shows that women were alone in coping with their sexual changes and that they did not know how to deal with them. Isabel, Mary and Linda had the same level of sexual desire and although they said that they did not experience any sexual changes, similar questions were put to them. They stated that they had not applied any method since they did not have any changes or problems.

One of them, Mary, believed that if she had a problem, the best solution would be to talk to her husband about it. She used the expression 'the elephant in the room' to emphasize how important it is to talk:

- Mary: ... I'm a true believer in talking about things I suppose. I think if you've got a problem. I think if you sit down you've got to find your time and your place you know, but I think that unless you sit you talk about things and explain how you're feeling, you don't know that the other person isn't feeling the same way, or feeling a bit differently, and I think talking is definitely a good thing. Whether

it is with your partner or whether it's, you know, with somebody else, I don't think it makes any difference really. Talking about things is the best way rather than just ignoring the elephant in the room, so to speak.

(Married, age 56)

Julie, who had a loss of sexual desire, spoke about talking to her husband about it a little bit. She emphasized that they had been together for many years and knew each other well, and that her husband was old and tired:

- Julie: ... Well, I mean, we, you know, we talked about it a bit. I mean, I think the thing is we've been together for over 20 years, so you know we're very we're very familiar with each other. And I think I, you know, as I say, he's older too and he's tired too and he's less fit too, so it probably wasn't quite the big deal that it could've been ...

(Married, age 57)

Trying out clothes and sex toys

Only two participants said that they had used clothes and sex toys in order to find solutions to their sexual changes. One of these participants, Nancy, first said that this situation was embarrassing to talk about but then she gradually started talking. First, she said that she had always had a good sexual relationship with her husband but that she could not have sex with the onset of the menopause. Nancy explained that she was upset that her husband was not having a pleasant time, and that they had bought sexual items and clothes that would increase their sex drive, such as sexy bras and underwear to please him. However, they had never used anything like this before the menopause and she admitted that the items which they used were beneficial for their sexual life. While still talking, Nancy was worried about whether it was right to talk about this topic, and as a researcher, I was able to understand this very clearly from her low voice, the reddening of her face and her disturbed speech. The next excerpt illustrates this:

- Nancy: Yeah well, we ... we've always ... my husband always got on really well, sort of sexually and stuff, so we've never used any of this before. But when I first started going through the menopause and I couldn't ... I couldn't have sex. I mean, I had to stop using lubricants and things like that and making it

mechanically happen. But my husband was like **upset** that I wasn't actually having having a **good time** so like I was obviously doing stuff to please him but it wasn't ... I wasn't actually having a good time which I wasn't bothered about really. But anyway, we bought some ... I don't know if this is what you want to know. (laughs)

(Married, age 59)

Linda said that sometimes she used some clothes because of her husband's lack of sexual desire; these were things like “sexy little bras”. She saw these clothes while out walking with her husband and bought them, and she said that they benefited from them. She also stated that she had some sex toys. She mentioned cock rings and said that it was probably her husband when I asked who had recommended it:

- **Interviewer:** *What kind of clothes? (laughs)*

- **Linda:** *You know. Sexy little bras and things. You know. Erm ... Early, when we were together early on, we bought things like that ...*

- **Interviewer:** *How did you decide to buy those clothes?*

- **Linda:** *So, I mean I've worn things like that before. A bit, not much. I don't know. Maybe we were out walking, and we looked in [a shop] window At the time I was doing some work with friends selling clothes and we would get ... it was like dressing up, fancy dress kind of, quite wacky clothes, but where you might get a corset and then you put us girls in it and so we had lots of clothes around.*

- **Interviewer:** *Do you think are they useful for your sex life?*

- **Linda:** *Well, it's good to have a mix of things. I think it's OK. Yeah. And then we had got some sex toys.*

- **Interviewer:** *For example?*

- **Linda:** *So, cock rings ...*

- **Interviewer:** *... Your husband recommended it or ...?*

- **Linda:** *Yeah. Probably it was him. Because it's a ring. Yeah. You put ... the man puts it down ... oh, right down the bottom. And I think it helps ...*

(Married, age 56)

She stated that her husband had an erection problem and that these cock rings were used for this purpose. She also mentioned another sex toy called a dildo. According to Linda, I should ask women about using sex toys or clothes because she thought that the use of sex toys is widespread, but some people may not want to talk about it:

- Linda: This cock ring is supposed to help, but it's kind of a sex toy thing. But also some dildos. ... You need [to ask] women [about this]. You should ask 'Do you use sex toys?' because some people might not tell you if you don't ask them.

(Married, age 56)

Participant narratives illustrate that women are really embarrassed when talking about these issues and have difficulty sharing information. This analysis showed that some women use clothes and sex toys as methods of coping with their sexual changes.

Watching videos and adult films

From the analysis of the responses, it was evident that not all the participants were interested in watching things like videos, adult movies or books as a solution to increase their sexual desire or deal with their sexual changes. It is notable that although the participants stated that they did not watch such videos, they said no, sometimes two or three times or sometimes protestingly. It is also notable that this situation actually showed that they thought that this was seen as a source of shame.

One participant reported that she was not interested in such things but that her husband probably looked at them. She also had a negative view of employing women for such things:

- Julie: That sort of thing doesn't interest me. I think my husband probably looks at things I don't want to discuss it and I think that pornography and the use of women in that business is a whole other discussion. I mean we, he's had a few problems as well as he's got older, which I think makes me feel better. I think, you know, from time to time, you know, maybe he's felt that because I didn't want sex very often, when I did want sex, it was really important that he had to have sex right now whether he particularly felt like it or not.

(Married, age 57)

According to Gina, who looked at the subject from a different point of view, such things were something that was done to increase sales, such as medication, films or videos, because sex was how the world works. In addition, she said that she didn't know if they were working and that if only half of the people thought they were working it was good for sales:

- **Gina:** *Well, I think like the like I just said, it is a lot of nonsense. It's a good way to increase your sales because sex makes the world go around. So, if you want to sell your product, if you claim that you're going to be more sexually active, then half of the population are probably going to believe what they want to believe, so they will buy it thinking that it's going to work. But I don't know whether it works.*

(Divorced, aged 57)

Masturbating

Linda also said that she wanted to develop her sex drive by masturbating, but while she was talking about it she felt embarrassed and I had to encourage her to talk about it comfortably:

- **Linda:** *I am trying to develop my sex drive again*

- **Interviewer:** *I see. What did you do? You said that you're making an effort. What do you do for waking it up?*

- **Linda:** *It's just about how you feel in yourself and with other people, and ... you know, masturbating. Yeah.*

(Married, aged 56)

Avoiding sex

In addition to the coping methods discussed above, one participant stated that she had developed her own methods to avoid sexual intercourse. She explained that she got out of bed quickly and was busy with other things, and that she tried to avoid sexual intercourse with excuses such as ironing and a headache. Instead of telling her husband that she did not want sexual intercourse directly, she used non-verbal avoidance methods because she did not want to upset him. She admitted that she could not continue this situation and that it made her feel unwell, as the next excerpt

shows:

- **Nancy:** *If I go all day **and all night and all day again** without even thinking about it, unless my husband starts trying to get close and then I would move away and pretend I've got something to do; and in bed in the morning I just jump out of bed quickly (laughs) and get ready. I've got to go and try and avoid [such] thoughts because I don't want to upset him by letting him think that I don't like him anymore Oh, I forgot; I do the ironing or do some [housework]. I'll make myself busy rather than try not to get into a situation very close.*

- **Nancy: Yeah exactly.** *(laughs, together). I'm not feeling too good. But you can only, obviously, you can't carry on doing that. But in the end I get a bit tired of [doing it] ... and in the end you get tired of saying the same thing all over again because he is typical of lots of men, but trying to explain to him what's happening, but then he'll forget and just think that it's his fault I had done it, and so it is quite hard.*

(Married, age 59)

Using vaginal lubrication and moisturizers

Some participants had often tried to reduce pain during sexual intercourse by using lubrication and moisturizers to deal with vaginal dryness and pain. The majority of the participants who had used lubrication believed it to be useful. On the other hand, one participant stated that she did not benefit from lubrication. Overall, however, the analysis shows that lubrication was beneficial for dealing with vaginal dryness and pain experienced during the menopause.

According to some participants, using lubrication is a detailed procedure and they prefer not to use it for vaginal dryness unless it was too bad, as they might experience a loss of sexual desire. When asked how they had decided to use lubrication or whether they had heard about it from someone, some respondents stated that they had not received any advice or information but had made the decision themselves, which might mean that the participants did not receive professional support and had tried to solve their problems themselves. Fiona stated that lubrication was beneficial but that her husband did not like the idea because it was not welcomed by her husband to do this practice before sex immediately. The fact that some men think that the lubrication which women use to ease their suffering of women means that they (the

women) do not like them once again shows the importance of partner support. Fiona was unhappy about her husband's dislike of her using lubrication:

*- **Fiona:** I use them and a cream, a moisturizer which allegedly plumps cells; I don't know which is better, but I had to persuade my husband first because he didn't like the idea. But this is better because you use it ... you don't use it just before sex. you use it all the time. It is like a moisturizer that you use all the time and it just helps things. So, you don't need to ... because I think it **upsets** him, the idea that he's, like, 'Oh yeah, we're going to be having sex, but just wait while while I go and insert some cream into myself first' (smiling).*

(Married, aged 64)

This analysis shows that the woman is looking for ways to avoid saying 'No' to her husband for sexual intercourse due to her lack of sexual desire. Most of the participants saw sexual intercourse as a duty towards the husband or partner. In the following superordinate theme, this topic is discussed in detail in the Men, menopause, and relationship (Superordinate theme:3).

Summary of superordinate theme 2

This superordinate theme has shown that most of the participants had a negative attitude towards using medication. The analysis showed that the use of HRT for dealing with sexual changes was not the first choice of the participants. Similarly, the analysis showed that alternative medicine was not seen as a preferred solution. On the other hand, it was shown that the participants tried to overcome the sexual changes which they experienced by using various methods which they considered appropriate. In the next superordinate theme, the results of the analysis will be presented on the reflection of these changes on their relationships with their husband/partner in greater depth.

5.3. Menopause, men and relationship (Superordinate theme 3)

As described in the theme of sexual changes, the participants stated that they had experienced many sexual changes during the menopause. This next superordinate theme examines in greater depth how sexual changes were reflected in their

relationships with their husband or partner. The analysis showed that all of the participants had experienced the effect of the menopause on their relationships.

This superordinate theme is presented under four subordinate themes: The perceived influence of the menopause on their personal relationship; Feelings, guilt and worry about the relationship; Having a supportive or unsupportive partner; and Women's views on how men understand the menopause.

5.3.1 The perceived influence of the menopause on personal relationships (Superordinate theme 3: Subtheme 1)

All of the participants believed that the menopause has a huge impact on women's relationships, including their own. When describing this impact, they used words such as 'definitely', 'exactly' and 'yes' (repeated) to emphasise their point. Only the women who had not experienced menopause symptoms and sexual changes too much said that the menopause had not affected their own relationship.

They stated that the menopause had affected their relationships in many different ways. For instance, Belinda said that she had felt a great emotional impact on her relationship because of the lack of sexual desire due to the menopause and she described that this situation as "really difficult". The analysis shows how the menopause is reflected in the relationship between spouses and how difficult it is to solve this situation.

*- **Belinda:** Yeah. So, I think that that's probably been the biggest change in terms of, kind of, my relationship.*

*- **Interviewer:** Mm. What is the biggest change?*

*- **Belinda:** Yeah. Just in terms of actually managing that with my partner ... erm ... I'm not feeling the same about sex as I did before the menopause so that's had a big impact. I think that's took ... erm,...it takes better negotiation between me and my partner about how we manage that, and I think that's difficult **really**. I think that's had a big emotional impact on our relationship.*

(Married, age 49)

Belinda also highlighted a state of emotion caused by a sexual change in the menopause: although they loved each other, there was a gap in their relationship, and this was a problem.

Most participants claimed that physical and emotional menopause symptoms negatively affected the relationship. In particular, some participants explained how hot flushes affect their relationships negatively. The participants who experienced hot flushes and sweating stated that they did not want their husbands to touch them. As can see excerpts:

- **Dawn:** *Already that only, like I said, the sweating and ‘Oh **don't come near me for a minute I am too hot, I am too hot**’ in the bedroom sleeping in bed, just sleeping. You want to go to a bed by yourself because you **too hot**. You're sweating all the time; you don't want anybody touching your skin or anything ...*

(Divorced, age 56)

- **Nancy:** *That's because if my husband comes to get to, like, hug me and I'm not, unfairly, **really hot**, I sort of just, like, push him away because it's too much.*

(Married, age 59)

In addition to hot flushes, some participants spoke about symptoms which negatively affected their relationship with their husbands which caused their energy to decrease, such as tiredness and sleep problems due to the menopause. According to the participants, when they were tired, had low energy levels and were sleepless, they were both more nervous and impatient, making them nervous towards the husband and thinking about sexuality on a lower plane.

It was clear from the analysis that emotional changes due to the menopause negatively affected the relations of the participants with their husband or partner. The participants thought that they experienced many menopause symptoms such as mood swings, crying, being overemotional, snapping, shouting and being in a bad mood, which could have an impact on their relationship. For instance, Elizabeth admitted that she was very horrible to her husband because of a bad mood, very impatient and for a long time she was not very nice. Like Fiona, Nancy stated that she screamed, “*screaming at him just AAWW, screaming, shouting because **he doesn't understand**”*, shouting at her husband in daily life. This analysis shows that the

symptoms of the menopause are reflected in the relationship and that the effects of the symptoms should be taken into account; not only the physical effect but also the relationship.

5.3.2 Feelings, guilt and worry about relationship (Superordinate theme 3: Subtheme 2)

The analysis shows that some participants were worried about losing their husband/partner or him finding another woman when they could not sexually satisfy him. The participants emphasized that women were afraid that their male partners would go to another woman for sex because their wives have menopause symptoms such as hot flushes, vaginal dryness, bad moods, mood swings or a lack of sexual desire due to menopausal reasons. For this reason, some participants felt they could not say 'No' to their man:

- Interviewer: And did you feel any worried about your relationship because of this?

- Dawn: Yes, yes sure. Yeah, I think maybe, maybe you think 'If I don't want to be doing these things in the bedroom, maybe he'll go to another [woman]'.

- Interviewer: Mm hmm. Did this affect your mood?

- Dawn: Yeah. Because I was afraid ... you're worried, right. I really must do this tonight with him because I don't want him to go to another [woman]. But I don't feel like it, so why can't I just say 'No'?

(Divorced, age 56)

In addition, one participant, Elizabeth, who was afraid of losing her husband and felt very sad, criticized herself, expressing her guilt feeling by saying that "I was treating my husband so badly that I would understand him if he left me". She also pointed out that she had experienced this change with the menopause before and that she had a very good relationship. Similarly, Julie explained that she could not look sexy to her husband with the symptoms brought by the menopause, but younger women would now look sexier, and this situation created a sense of threat. In addition, she said that not having children also played a big role.

Furthermore, Nancy admitted that she had become obsessive (her own word) about her husband's cheating and that she had never had this feeling before. She talked about seeing her husband sitting with another woman and following her husband and she was checking on him by sending a message and that her husband was responding to her in a correct way, and she expressed her feeling that *"my blood was boiling"*. The analysis illustrates how women who are afraid of losing their husband/partner for reasons related to the menopause are psychologically affected.

In addition to the fear experienced, two participants, Gina and Helen, stated that the biggest factor in the breakdown of their relationship was the menopause and their problems with it.

5.3.3 Having a supportive or unsupportive partner (Superordinate theme 3: Subtheme 3)

Five participants stated that their husband/partner supported them during the menopause in different ways. For instance, Angela and Camila said that their partners were understanding in this period. Angela's partner was very calm and she felt less stressed while he was around. Nancy and Angela similarly said that their husband/partner was understanding and respected their wish not to have any intimacy. Like Angela, Mary stated that her husband did not react negatively towards her when she was irritable, told her not to be upset, offered her a cup of tea and talked about funny things:

- Mary: Well it's just, he listened; he is not [upset] if I get a irritable or what have you. He does not react as a, you know, sometimes people just; they sort of, you know, lock horns, don't they. He just sort of says, you know, 'All right, don't worry about it; sit down and I'll make a cup of tea', you know.

(Married, age 56)

Mary and Isabel, who thought that their husbands were supportive, were those who stated that they did not experience too many menopausal symptoms and that there was no change in their sexuality. Isabel said that she always had a good relationship with her husband and Mary said that she had married her husband only five months previously. Both the few symptoms of the menopause and the good relationship which

they had are two points to consider. Interestingly, Camila believed that the fact that they did not live in the same house was helpful in this situation. She thought that things would have been different if they had lived in the same home.

It was particularly noticeable that all these women talked about the attitude of their men happily and it was clear that they were happier than the other participants. The analysis showed that men can support women by reducing their stress levels and making them feel better.

Women who could not say 'No' to their husband/partner's desire for sex due to their own lack of sexual desire were discussed in the theme of sexual changes. In addition, some participants stated that they had a duty for sex towards their husband/partner. According to Nancy, sex was a duty for married life and she had done a self-evaluation and she believed herself to be 'old-fashioned' about that. Similarly, Gina believed that no sex destroyed the relationship but in contrast to this opinion, she stated that "the duty for me as I've got older is that I have to feel no obligation to anybody to do anything (laughs)". This analysis showed that some women believed that sex was very important in the relationship and that they saw it as the cornerstone of the relationship and so felt responsible towards their husbands for sex.

5.3.4 Women's views on how men understand the menopause (Superordinate theme 3: Subtheme 4)

Many of the participants believed that men in general did not have a knowledge or awareness of menopausal symptoms. Men were far from understanding the participants' problems. For example, the women thought that when they had a low level of sexual desire, this was not understood by most men and that it might even lead to divorce as a result of them saying 'No' to sex on a regular basis. The majority of the participants believed that men should learn about the menopause and need to accept it because these are problems related to the menopause:

- Dawn: Because if she loses the emotional feeling, he won't understand. Maybe. Maybe some men. Well, some men won't understand. And if you lose that sexual feeling, how can you make him happy and make him enjoy it. At night times, if you're not enjoying it ... and you're saying 'no, no, no'. maybe it could cause a divorce. Maybe shouting. Upsetting for the woman. Upsetting for

*the men also, but in a different way. He's got to understand. And I think more men should learn about the menopause and see how the woman feels. We have periods, we have babies, then we have the menopause. It's **hard being a woman.***

(Divorced, age 56)

*- **Gina:** Because of their lack of understanding, a man's lack of understanding, lack of empathy, lack of tolerance, lack of patience. Because erm... (7) men want to have their needs met ...*

(Divorced, age 57)

Similarly, Fiona thought that the physical effects of the menopause affected her relationship with her husband emotionally and she said that her husband did not understand the symptoms of the menopause and she thought that he felt guilty. In addition, Fiona said that for men of her husband's age, the menopause only meant not having children, so he did not know what other problems there were and therefore did not know how to cope:

*- **Fiona:** I think for a lot of fellows of his age group it just means you can't have kids anymore and that's all it meant, and they didn't realize it came with a whole raft of other problems and things to be coped with.*

(Married, age 64)

Fiona emphasized that they still loved each other and still had sexual intercourse, but that it was not easy at all. In addition, she felt unattractive because of the menopause and this knocked her husband's confidence and made him think that he could not excite her. Like Fiona, Gina stated that her partner probably internalized low levels of sexual desire and felt rejected. This analysis showed that men can see the menopause only as losing the fertility of the woman and for this reason, they do not understand the symptoms of the menopause and men can hold themselves responsible for the relationship problems. Furthermore, Angela stated that men see the menopause as a crazy thing and she believed that when there is more open discussion, more men will listen, and this will help to solve the problem. Gina said the same thing: "Maybe we should have had more of an open discussion about these things **specifically**". This

analysis showed that some women thought that talking to men comfortably about their problems could help them to solve their relationship problems.

Summary of superordinate theme 3

The analysis of the accounts of the participants showed that the relations of the participants were greatly affected by the changes experienced with the menopause. The emotional sensitivity, fears, guilt and difficulties experienced by some participants were analysed. The analysis showed the importance of a supportive attitude by the partner or husband. In addition, the analysis showed that the view of most of the participants was that men do not have enough knowledge about the menopause. In the next superordinate theme, the results of the analysis of how the participants struggled with the menopausal symptoms which they mentioned frequently will be presented.

5.4 Managing menopause symptoms (Superordinate theme 4)

This theme addresses how the participants looked for solutions to the problems experienced in the menopause and how they approached their problems. Almost all of the participants complained frequently about menopausal symptoms. They mostly used natural methods for their symptoms. In general, they had a negative perception about using medicine and HRT because some participants considered that there was a risk of breast cancer as the principal reason for not using HRT. Many participants reported that they had used a variety of ways to deal with menopausal symptoms. Some participants considered that using HRT was equivalent to using medication.

These coping methods are presented under the three subordinate themes: Perception, attitudes and knowledge about HRT; Managing menopause symptoms by applying natural, sport, exercise and healthy food; and Managing menopause symptoms by applying alternative medicine, herbal tea and various products.

5.4.1 Perception, attitudes and knowledge about HRT (Superordinate theme 4: Subtheme 1)

As discussed under superordinate theme 2, the participants reported negative opinions about using medication for dealing with their sexual changes. Likewise, most

of the participants had a negative attitude towards using medication to deal with many menopausal symptoms. These participants said that they were reluctant to use medications in general and that they did not take much medication apart from some for important health problems. Dawn explained clearly that she only took medication for asthma and she had to do it, but she did not want to use any medication for the menopause:

- Dawn: Because I've not taken any medication for my menopause. Nothing. I don't want to take medication. I want to try and work through it myself.

(Divorced, age 56)

Much like Dawn, Angela thought that “medication should be the last step and never the first” because she believed that overuse of medication caused some addiction problems. Some participants' reluctance to use medication may be associated with choosing to do anything other than HRT for the menopause as some of these participants stated that they preferred not to use HRT because they did not like to take medication. In fact, they established a linear relationship between the two perspectives on medication and HRT. For instance, Angela stated “*I do not want to take HRT or antidepressants ...*”. This result showed that some participants had a negative perspective towards the use of HRT because antidepressants and HRT might be considered to have a similar negative effect.

Just over half of the participants said that they did not use HRT during the menopause and eight said that they did not want to use HRT. Some participants gave explanations for the underlying reasons for not wanting to use HRT:

- Gina: And there's nothing to be done. Well, I didn't take any HRT. I didn't. I have taken no medication. Perhaps, perhaps, perhaps I should have done it. But I'm not really a person who takes medication for anything really.

(Divorced, age 57)

This extract above shows that one of the reasons for not wanting to use HRT was the lack of willingness to use medication. This implies that the participants considered HRT as a medication. On the other hand, by saying “*I should have done it*” and repeating ‘*Perhaps*’ three times, she demonstrated that she was not sure exactly whether her choice was correct or not.

Several participants indicated that they dealt with menopausal symptoms without using HRT and did not need it. Isabel said “*I haven't felt the need yet*”, Kath said “*No, I haven't, I haven't needed it, I haven't needed it*” and Mary said “*I thought the symptoms weren't that bad to warrant taking it*”. These women's menopausal symptoms were not too severe and they saw this as another reason for not needing HRT. In addition, Elizabeth stated that she did not use it because HRT was not recommended by her GP:

- Elizabeth: So, when I went to talk to my GP and he was the person that diagnosed that I was suffering with mental and physical symptoms of the menopause I thought he was helping me but he wasn't helping me because he didn't give me HRT. He said he wouldn't prescribe HRT because of all the risks and I just accepted it because I didn't realise, I didn't have any knowledge or anything. He was the family doctor. So you accept what your family doctor says, but now because I've learnt so much I wish he'd given me HRT because I might be at risk of osteoporosis and other problems. I also had an occupational health referral at work and they weren't very good. They weren't very experienced or knowledgeable about the menopause either.

(In a relationship, age 47)

There are a few significant things to note in this quotation from Elizabeth. She first stated that she actually had difficulty due to menopausal symptoms. She claimed that HRT was not recommended to her by her GP and that she did not have knowledge about HRT, in addition, Elizabeth believed that this decision was not right for her and that she wished that the doctor had given her HRT. This analysis showed that some of the participants lacked information about HRT, and this is therefore where doctors and health professionals play big roles.

Another reason for some participants not wanting to use HRT was that the possible side effects of HRT outweighed the benefits. Among the possible side effects, these participants thought that HRT often had the risk of causing breast cancer. Although they did not articulate that they fully believed this, they said that they heard about this risk from their friends. This analysis implied that this perception possibly affected their decision not to use HRT.

Some of the participants who used HRT stated that hearing positive opinions about HRT from their friends and the doctor's suggestion had an effect on their decision to start HRT. Unlike other participants, Camila made it clear that she made this decision on her own and went to the pharmacy and started using it.

On the other hand, when looking at the opinions of the participants about using HRT, some interesting findings were made. Some of the participants stated that they had unbearable menopause symptoms as the reasons for using HRT. In this context, Julie said that the main reason for starting HRT was physical problems like hot flushes which had become intolerable.

Belinda stated that she started HRT because she had had an early menopause (menopause age was 42). She explained the troubles which she experienced due to her unwillingness to use animal products in HRT because she was vegan. She said that after the first GP did not help her, another Muslim GP had helped. In this analysis, the approach of GPs to people who are vegan is important.

The analysis demonstrated that with the use of HRT, the symptoms of the menopause which they had complained about decreased and some of them disappeared. We can see in the next extract that HRT was described as a 'miracle'. Camila looked incredibly happy talking about HRT. The greatest proof of this was when she said that she has regained her life thanks to HRT. From this analysis, it was clear that some of the participants had had incredibly positive benefits in their lives by taking hormones:

- **Camila:** *Yeah. So, this is **very, very, very important.** This is the message I want to tell you and anybody that 48 hours after I took that one tablet, **I got my life back.** And that is what I'm trying to spread the word about. My life went **completely** back to normal. So, every symptom that you've written down, every symptom that I was having, stopped after 48 hours.*

- **Camila:** ***Absolutely incredible. More than great. A miracle, miracle.***

(In a relationship, age 47)

In addition to the symptoms of the menopause, Julie explained that HRT was beneficial for situations such as trouble sleeping and feeling bad. A remarkable finding was that one participant said that she started to feel very bad due to the menopause and even wanted to kill herself. Nancy admitted that there was no reason for this and

she was also embarrassed to have had this thought. With the use of HRT, Nancy said that she got back her 'old self'. Another benefit of HRT described by other participants was that their breasts had swelled and regained their previous shape, which she said made her feel "so much more attractive". This analysis highlighted the benefits of HRT and the importance of breasts for feeling more sexually attractive for some women.

- **Nancy:** *I felt like I, I just didn't want to live anymore, just that it would, just, it just came down. It just came down like a big dark cloud and I just ... I was ... I just felt so low and I couldn't walk. I just felt so ashamed because I was thinking there's no reason for me to feel like why am I feeling like this. I have no reason because everything in my life was fine.*

(Married, age 59)

Although the reasons for starting HRT were not sexual changes, some participants stated that they had regained their lost sexual desires thanks to it. For instance, Fiona said that HRT solved her vaginal dryness and sexual desire problems, but that she had had to stop using it because of leg pain, which is a side effect, and the menopausal symptoms returned. She explained this clearly:

- **Fiona:** *So that made things easier, but I went to the doctor because I was getting like a pain down the side of my leg and it was like, like a trap. That's what I thought it was. So I went to the GP because I couldn't think what I'd done. And I wondered if there was anything, exercises or something, I could do. And he looked at my nose and he said 'You're taking HRT; it's one of the sides effects that you get swelling in the, the sort of, canal area there, the soft tissue there, and you are pinched in the neck.*

(Married, age 64)

Nancy, like Fiona, explained that after a while using HRT, her already existing fibroids started growing again with the oestrogen and started bleeding, so she had to stop using HRT. This analysis implied the necessity and importance of controlling women on the side effects of HRT. In summary, this subtheme has illustrated several opinions about HRT. Within this study, although the participants' perceptions of HRT were mostly negative, some participants stated that they were very pleased to receive HRT and regain their lives.

5.4.2 Managing menopause symptoms by applying natural, sport, exercise and healthy food (Superordinate theme 4: Subtheme 2)

In order to solve the symptoms which they experienced in the menopause, most participants wanted to go down the natural route as long as possible without taking medication or hormones. They tried to cope with this situation by keeping themselves cool for the hot flushes which are one of the most frequently complained about menopausal symptoms. Some of the methods which they used frequently when they felt warm were opening the neck of their clothes, standing outside, waiting, getting out into a bit of fresh air, taking clothes off (especially socks), opening windows and using cold water. In addition, they tried to prevent these symptoms by taking precautions before the hot flushes and night sweats started, such as wearing thinner pyjamas, preferring cotton bedding, using a fan (especially in the bedroom), keeping the windows open during the night and using gel pillows to help them to stay cool. This is shown in the following extract:

- Julie: I made sure that ... I mean, all of my bedding is cotton so, you know, that's the best thing you can do. I had a fan in the bedroom so I'm in bed with a sheet and a fan and my husband is under a duvet with the windows open. So I make lots of physical attempts to just make it bearable.

(Married, age 57)

Most of the participants reported that they were exercising to manage the symptoms of the menopause. In other words, they sought ways to feel better by swimming, walking, running, yoga or meditation. For instance, Angela believed that it was much more beneficial to walk with a group of friends or pets and that she had realized this after having a pet and joining running groups.

Some of the participants said that they had changed their eating and drinking habits and preferred to eat more healthy foods. When asked what healthy foods meant for them, they explained that they consumed more fresh fruit and vegetables and avoided processed foods. In particular, they thought that it was necessary to stay away from alcohol, carbonated beverages and caffeine. Furthermore, they believed that caffeine should not be used as it affected them negatively.

5.4.3 Managing menopause symptoms by applying alternative medicines, herbal tea and various products (Superordinate theme 4: Subtheme 3)

The analysis demonstrated that most of the participants had turned to complementary and alternative medicine to get rid of menopausal symptoms. Some of them said that they were more interested in alternative medicines and herbal medicine. They preferred alternative medicines because they are natural and also they did not want to use medication such as HRT.

When they were asked whether they had benefited from using alternative and herbal remedies, a few participants responded that they were not completely sure and so they thought that these might have a placebo effect. In contrast, most of the participants stated that by using them, they had achieved significant benefits and that their problems such as hot flushes, sleeping problems and anxiety had decreased. In this regard, Linda stated that alternative medicine and herbal remedies had contributed to rebalancing.

Some participants stated that like Helen, they regularly visited a medical herbalist and that it was really useful. In addition, Helen highlighted that she preferred to go to a herbalist instead of a GP because she thought that the herbalist was beneficial and her symptoms were not severe. Participants noted that things like alternative medicine and herbal remedies often began with the advice of their friends, as a result of their own internet research and readings, or on a GP's recommendation. In summary, most participants had a positive attitude towards alternative medicine.

There were a variety of alternative medicines and herbal remedies which the participants reported seeing benefits from in different ways. These included Black Cohosh, cod liver oil, green tea, herbal sleeping tablets, herbal tablets, herbal tea, St John's Wort alternative medicine, lavender oil, lavender spray, maca powder, primrose oil, sage, sage tincture, soy, starflower and starflower oil.

Summary of superordinate theme 4

The analysis showed that the participants were more inclined to use natural methods and alternatives and had some concerns about using HRT. In the next superordinate

theme, the meaning of the menopause, knowledge, talking about the menopause and the effects of the menopause on the participants' lives will be presented.

5.5 The meaning, knowledge, talking about the menopause and the influence of the menopause on women's life (Superordinate theme 5)

In this superordinate theme, positive, negative or neutral opinions of the participants were given on how they made sense of the menopause. Findings of how much they knew about the menopause, their experiences of talking about the menopause and their preferences were given. Another important finding was how the menopause affected their social, work and family lives, except their close relationships.

This superordinate theme is presented through four subordinate themes: The meaning of the menopause to the women; Pre-existing and current knowledge about the menopause; Talking about the menopause with friends, family members, healthcare providers, GPs and people from different circles; and The impact of the menopause on other areas of women's life.

5.5.1 The meaning of the menopause to the women (Superordinate theme 5: Subtheme 1)

The participants tried to define the menopause with their own expressions, using metaphors, non-verbal expressions and sometimes crying while talking. They described the menopause in the following ways: being a grandma, reverse puberty (mostly), a sort of transition to older women (mostly), end of fertility (mostly) only some voices like off off, very difficult, natural stage, debilitating, end of being attractive, sadness, loss of power, loss of visibility, closing chapter, not sexually interesting stage, end of being able to have children, empowering time, nuisance, end of one life and the beginning of another, and really golden years. It was clear from the analysis that the participants often used non-positive statements when describing the menopause. In fact, this analysis implied that the women did not see the menopause very favourably.

Although the participants used more negative expressions when defining the menopause, the analysis also showed that it had some positive meanings for them. The participants often stated that they felt more comfortable and free due to the end of menstruation. This is evident in this excerpt from Kath:

- **Kath:** *Um, I felt glad that period ended. I didn't have to worry about that anymore. (laughs)*

(Divorced, age56)

Helen also emphasized that she felt very glad because of no more period pains. Particularly interesting was that Angela, in a different thought from other participants, admitted that the menopause gave her a chance to have lots of sex without the risk of unintended pregnancy.

The participants stated that the negative opinions about the menopause outweighed the positive because of losing the chance to have a child and having the adverse effects of menopause symptoms. Angela highlighted that she felt sad:

- **Angela:** *I think in the beginning it was **very negative because** I did not want to have any more children up until I knew I could not have any more children, and as soon as I knew I could not have any more children. I actually felt sad. So, yeah, it was an end and then to me and an end to that. To know that was what I thought would make me happy initially made me sad.*

(In a relationship, age 51)

Isabel, who had no children, stated that this was her preference, but she started to cry while she was talking. Even though it was her preference not to have children, the fact that this chance was eliminated by the menopause had deeply upset her. Like Isabel, Elizabeth almost cried about not having children and losing the chance with the menopause. Another frequent issue was that their lives were difficult because of the symptoms of the menopause and therefore they had negative feelings towards it. Furthermore, some participants, like Camila and Julie, stated that they could not see any positive side of the menopause except for no more menstrual periods with these words:

- **Camila:** *'Can I see any positives in the menopause?' **No, really, I can't.***

(In a relationship, age 47)

- **Julie:** *There is nothing good about the menopause apart from the periods going. No more periods [they are a] huge nuisance, expensive, uncomfortable. No, no, no, no periods.*

(Married, age 57)

5.5.2 Pre-existing and current knowledge about the menopause (Superordinate theme 5: Subtheme 2)

Most of the participants thought that they did not have enough knowledge about the menopause. Some admitted that they had no knowledge, especially at the onset of the menopause. On the other hand, the participants said that information about the menopause was usually obtained as a result of their own efforts, which included doing their own research on the internet. The analysis demonstrated that the participants mostly used the internet and Google to obtain information about the menopause. Some usually researched the symptoms of the menopause on the internet and then compared what they read there with the symptoms which they had experienced. Social media were used to get information about the menopause by some participants:

- **Elizabeth:** *And also, there are many campaigners on social media like Louise Newson [a GP who specialises in the menopause] who are trailblazers and I learned [from them]; they always print free information ...*

(In a relationship, age 58)

Some of the websites which the participants used were the Menopause Matters website, the NHS website; the British Menopause Society and the National Institute of Health Care Excellence (NICE) guidelines.

Television and radio programmes also provided useful information about the menopause. For instance, Camila and Julie listened to Woman's Hour on Radio 4, a specific programme for women which from time to time talks about the menopause. Mary said that she had watched a television programme and suggested it to her husband:

- **Mary:** *Well, I'd already watched it but I did suggest that he watch it and he did watch it and he said that he understood a lot more [about it after watching it].*

(Married, age 56)

Some participants obtained information from their friends, including books which their friends recommended:

- **Belinda:** *... I've had a couple of people recommend books or articles to read and then some of it's been just word of mouth.*

(Married, age 49)

It is notable that some women did not mention members of their families such as mom and sister while talking about this issue. Similarly, only a few participants mentioned the GP as a source of information and said that they were only given things such as leaflets. This analysis implied that women tried to obtain more information about the menopause individually and that any professional support was not enough. Most participants wanted to have information about the menopause.

5.5.1 Talking about the menopause with friends, family members, healthcare providers, GPs and people from different circles (Superordinate theme 5: Subtheme 3)

The analysis revealed that all of the participants talked about the menopause with people from different circles, such as a friend, partner, husband, family members (mother, daughter, son, sister, brother and so on), the GP, healthcare providers, colleagues, some womens' groups (the menopause café, running club, Facebook menopause groups) and medical herbalists. It is also noteworthy that some participants said that they had talked to "*a lot of people about the menopause thousands of times, lots of conversations*", whilst others said that it was "*not much*". Importantly, most participants noted the importance of talking about the menopause.

In general, most of the participants, as their first choice, shared their experiences with the people they saw as friends, but some participants emphasized close friends, not all friends. The participants often talked about menopause symptoms (especially physical and emotional symptoms), comparing their menopause symptoms with one

another, treatment methods and the negative effects of the menopause within a general framework with friends. However, a few participants initially stated that they talked with their husband about the menopause before talking to their friends.

Some participants talked about the menopause with their husbands or partners but most said that they could not explain many things to their husbands because these participants stated that men cannot tolerate negative things and do not want to listen to them.

When the participants stated that they talked about their physical (insomnia, hot flushes, sleep problems) and emotional (overemotional, tearful) situations with their husbands, they said that they had difficulty in talking about sexual issues such as vaginal dryness and pain. For example, some participants believed that men considered talking about vaginal dryness as embarrassing:

*- **Fiona:** Yes and no. [he's] quite old-fashioned as you can imagine, my husband. So it was like if there was something wrong then you could say and they go, you know, so 'Well, should not you see a doctor?' and I said 'Well it is part of the menopause. It is just part of the thing that I am going through'. And that would be it. I think he was not always totally sympathetic with it. I found that I was more emotional, quite tearful about things, sometimes and he would find that embarrassing and would not want to talk about it.*

(Married, age 64)

Similarly, Belinda drew attention to the same situation, saying that she could not talk to her husband about vaginal dryness. Gina also stated that her partner was not open to discussion at all about the menopause. Helen, who clarified this situation in more detail, said that there was no conversation between her husband and the menopause at all and that her husband would not tolerate listening to it. The reason for this was that her husband found the subject repulsive. Helen believed that "*Men thought it was horrible to talk about women's bodily systems*".

Some participants who talked to their mothers reported that they had talked about their mothers' past experiences and compared their menopause symptoms. Others, however, claimed that their relationship with their mother was not close enough to talk about these issues, and their moms were not open to discussing these issues. There

was therefore diversity regarding whether or not participants had spoken with their mothers about the menopause. This finding implies that mothers can be a source of support for their daughters during the menopause.

Furthermore, the analysis clearly showed that some of the family members did not take the symptoms of menopause experienced by women too seriously and reacted negatively to them. Some of the participants who had a son mentioned situations in which their son had problems in understanding and supporting them in the menopause, whereas those with daughters did not make any complaints about this issue. In this analysis, it can be said that there is a difference in how sons and daughters responded to their mother's menopause. This is evidenced in the following excerpt:

*- **Gina:** I mean they can all see me, you know, they can stay there watching me taking my clothes off and putting my clothes on ... So, my eldest son said to me that, he said 'Oh nobody ever died of the menopause'. So, he was sort of dismissing my problems and said nobody ever died of the menopause. And I think that is not true because I think that there are some women who might get very depressed and kill themselves.*

(Divorced, age 57)

Moreover, although some participants talked with their sisters, others said that they could not talk to their sister about the menopause very easily for reasons such as uterus removal due to health problems experienced by their sister. Analysis showed that some participants talked to their brothers about their own menopausal experience and complaints, as well as, for example, their brother's wife's experiences. On the other hand, some participants stated that they did not talk to their brothers, saying that they thought that it is very embarrassing to talk about these issues with a brother. This might suggest that the menopause is a gendered issue.

The analysis showed that most of the participants had had very short conversations with their GP and these conversations had focused on the physical effects of the menopause and HRT in general. In particular Dawn believed that her GP had not given her enough information. Dawn used the words 'not really, not enough' with emphasis.

Furthermore, as is clear from the next excerpts, the participants believed that they did not talk enough about the menopause with their GP:

- **Fiona:** *there was no offer, no discussion ... I went when I first started experiencing what the GP said were symptoms and tenderness and the hot sort of flushes and mess, and I have to say, I thought the GP was **really rubbish**.*

(Married, age 64)

- **Gina:** *I think that the conversation was quite a short conversation which just said 'Yes', Just 'Yes, you are going through the menopause'. And in terms of how that affects your well-being and your day-to-day life and things, I don't think that it was really spoken about too much. I think maybe she might have asked me about HRT, but I wasn't receptive to that, so I wasn't really that interested in pursuing it.*

(Divorced, age 57)

According to some participants, in addition to having a negative opinion about the GP as explained above, some of the participants who had had bad experiences made it even more obvious. For example, Belinda stated that the GP was not very friendly and did not provide her with sufficient information and support about HRT:

- **Belinda:** *... I didn't particularly like that doctor, he was a bit ... erm ... what is the word ... he was not very friendly, not very warm. Did an exam and checked things and went 'Yes, definitely menopausal'. So, at that point things changed a little bit; people listened so then I start thinking about HRT which was recommended because of my age because of worry about bone density and what might happen. So, I wanted to have some HRT that wasn't animal derived, but was plant derived. And none of the GPs were interested. I asked for help in looking at 'What's the ingredients', 'What does HRT come from?'. No-one was interested in helping at all.*

(Married, age 49)

In contrast, some participants like Camila mentioned good experiences from a GP appointment. Camila also stated that the process of getting a GP appointment is very long, and she said that after calling "forty-five times in a week", she eventually got an appointment with the GP two months later. She stated that she was worried about how

to explain all her complaints since the appointment meeting was only ten minutes, but because it had been the last meeting of the day, the GP could spare 30 minutes and listened to her.

The participants were asked if they felt comfortable talking about the menopause. Some of them said yes but others admitted that they were embarrassed and did not feel comfortable talking about these issues. Furthermore, the analysis showed that even if some participants were comfortable talking to their friends about the menopause, their friends would not openly talk about the issue and felt embarrassed. According to some participants, the underlying reason that their friends felt embarrassed when talking was that they might have a sense of feeling vulnerable. In particular, Julie defined herself as open-minded about talking about menopausal issues, especially sexual issues, but she said that her friends felt less comfortable talking about it.

In addition to the participants who complained that their conversations with their GP were both inadequate and mostly about the physical effects of the menopause, others said that they did not feel comfortable while talking with the GP.

There were participants who felt comfortable and others who did not feel comfortable talking about the menopause with their partner or husband. The analysis showed that the biggest reason why the participants felt comfortable or not was whether the partner or husband wanted to listen to them and whether he had a supportive attitude:

- Belinda: I always feel comfortable talking to my partner because he listens better than most people I've ever met ...

(Married, age 49)

5.5.4 The impact of the menopause on other areas of women's life (Superordinate theme 5: Subtheme 4)

The analysis revealed that the symptoms which participants experienced during the menopause affected the rest of their lives, including their family life and their work and social lives, apart from their close relationships with their husbands and partners. Menopausal symptoms not only affected the relationships of some participants with their partners (see below), it also could affect the relationship with their children.

According to the participants who talked about family life, especially their relationships with their children, they stated that sons had difficulty understanding this situation and felt that their menopausal status was exaggerated and therefore they had an inconsiderate attitude. Some of the participants felt guilty about their children. They confessed that they yelled at their children because they were impatient and irritable because of menopausal symptoms.

*- **Angela:** So, the impact that it's had on my life though, the biggest impact it's had on my life so far, was last year. When I was 50, I had six weeks of not sleeping and my daughter came up for my fiftieth birthday and I was **so tired**, and she'd arranged lots of things and I didn't know what was happening and I was so **grumpy**. I shouted and I have never shouted at my daughter before and she never shouted out as she was 30. She did not understand what was happening because I have never shouted at her before so that was really sad. That was after six weeks of not sleeping and her not understanding the effect that it was having on me. So far, the biggest impact has been that: I had **a really difficult day** where I upset my family with my menopause symptoms.*

(In a relationship, age 51)

In this extract, Angela explained that her daughter was preparing a birthday surprise for her, but she could not even realize that it was happening for this birthday because of her insomnia, because she had had a sleep problem for about six weeks. It was the first time that she had ever shouted at her daughter and this made her very upset. This analysis implied that the effects of the symptoms caused by the menopause are also reflected in the relationship with other members of the family, especially with (grown-up) children.

Many menopausal symptoms such as forgetfulness, hot flushes, sleep problems, fatigue and brain fog were found to cause difficulties in their work lives and problems had arisen for this reason in the women's lives.

*- **Elizabeth:** So, so, so the brain fog and the stress and the lack of sleep. Once I started to rest and take care of myself, I didn't go to work for four months; I was sick for four months.*

(In a relationship, age 58)

This above excerpt suggests that work was interrupted due to excessive menopausal symptoms, insomnia and brain fog. In addition, one participant stated that her colleagues were younger people and that during her menopause symptoms, for example, when she was experiencing hot flushes, those around her laughed at her, and she noted that her younger colleagues had difficulty understanding menopausal symptoms:

*- **Angela:** Work was **very, very difficult**. Work was very difficult and thankfully my boss was a female. So she was very understanding, and I would take rest breaks at work or I would work for a half-day or I would take time out; I would take some holiday.*

(In a relationship, age 51)

As can be seen from this above extract, although there were participants who said that they had difficulties during the menopause, it is important to be supportive and to support women during this period. According to Belinda, there had been times like that and it had reached the point of crying at the workplace. Camila also stated that her mental recall problem was affecting her success at work and she felt incompetent and unhappy with this situation. This analysis implies that a woman's work life is deeply affected by the menopause and that certain rights should be given to menopausal staff at the place of work. For example, flexible working hours and adjusting the working environment in order not to make menopausal symptoms more difficult.

The analysis demonstrates that the participants had to move away from social life and preferred to be more lonely due to the menopausal symptoms which they experienced and this situation made them unhappy. For example, the participants with lower energy and tiredness could not spare enough time for socialization because they could not have enough energy, even if they wanted to. Women with excessive bleeding problems had avoided socializing because of the fear of stains on their clothes and the appearance of excessive sweating due to hot flushes on their clothes. They preferred not to go to crowded places such as theatres and bars or sometimes anyone else's house. Moreover, as can be understood from the next extract, Elizabeth described herself as '*reclusive*':

- **Elizabeth:** *No, I felt very reclusive; I didn't want to go to parties I didn't want to do anything because I felt, I just felt as though I felt very empty socially ...*

(In a relationship, age 58)

Clearly, menopausal symptoms can make women feel isolated during the menopause, and indeed, with this isolated life, they enter an even more difficult period psychologically.

Summary of superordinate theme 5

This superordinate theme has made clear what the menopause meant for the participants. As a result of the analysis, it was seen that most of the participants did not have sufficient knowledge about the menopause. For most of them, it can be said that they were very inclined to share and talk about their menopause experiences, but these conversations were found to mostly focus on the physical changes of the menopause, and that they had difficulties talking about sexual issues. The analysis showed the effect of factors other than the participants on the participants' talking about menopause. The analysis has also shown that the menopause affects many aspects of women's life, except only in a close relationship. This once again shows the importance of the holistic point of view, which is frequently mentioned throughout the thesis.

CHAPTER 6: DISCUSSION

Introduction

In this chapter, I shall discuss the similarities and differences between the findings obtained for this thesis and those in the existing literature. At the same time, I shall explain what has been added both theoretically and methodologically to the existing body of knowledge on this subject beyond what we already know. As far as I know, this is the first IPA thesis on post-menopausal women's experiences of the menopause and the perceived impact which the menopause can have on their interpersonal relationships and intimacy, and the coping methods which they use. Based on the findings through this thesis and the information in the literature, I also dwell on the contribution to knowledge of what is beyond what is currently known. I shall discuss these findings in detail in section of 6.4.

This chapter also includes a reflexivity section (section 6.5) in which I shall examine how my role as a researcher may have affected the development of the thesis, and the contribution to knowledge which it makes. Finally, I shall discuss the strengths and limitations of this thesis.

6.1 Links between the Menopause and Sexual Changes

6.1.1 Experiencing sexual desire at menopause

The findings of this thesis have shown that most of the participants had an loss or reduction of sexual desire. There are qualitative studies supporting the fact that the menopause affects women's sexual changes and that they experience low sexual desire (Moghasemi et al., 2018; Yang et al., 2016; Hyde et al., 2011; Ling, Wong, & Ho, 2008). In a study conducted in China, Ling et al. (2008) found that the majority of women, 80-90%, experienced loss of sexual desire after the menopause. Nappi and Nijland (2008) reported that one-third of the post-menopausal women (34%) experienced a decreased sex drive and that half of them (53%) were less interested in sex in their quantitative study of 1805 European post-menopausal women. The findings reported from qualitative and quantitative studies are important to see the prevalence of low sexual desire among post-menopausal women. In addition to the

prevalence of sexual desire issues, it is possible to say that when we consider the findings from this qualitative thesis, from women who believed that this influence lasts for years, this issue should be solved because it plays a central role in the lives of women.

Among the reasons for the lack of sexual desire for the participants in this thesis, there was a belief that the menopause was a major factor and that hormonal changes and ageing also affected the process. These results are similar to the sexual changes experienced with menopause which have been reported in the literature. The fact that women believe that one of the causes of many sexual changes such as lack of sexual desire which they experience is the menopause has also emerged in this thesis and similar studies. For example, in a similar way in another study, most participants claimed that the changes caused by menopause had important physical and hormonal effects which caused a decrease in their sexual desires (Ling, Wong, & Ho, 2008).

In another study, women were asked how the menopause affected them sexually, and some stated that it played a minor role whilst others said that when they had symptoms such as hot flushes it naturally made them not interested and they avoided sex (Wood, Mansfield, & Koch, 2007). As can be seen from this thesis analysis and other studies, it can be said that menopausal symptoms lead to a decrease in sexual desire in women's life. For example, at the symptom of hot flushing, one woman in this thesis did not even want her husband to touch her. This result showed that the multiple influences of the menopause should not be ignored because they can have negative impacts on a woman's sexual life.

This thesis revealed that loss of sexual desire may be connected with other factors and is not just related to the biological factors of menopause. The causes which occur alongside the menopause, such as the husband's bad behaviour and violence, can lead to a decrease in the sexual desire of the woman. As can be understood from this, the menopause is not the only reason for low sexual desire. Similarly, a different study reported that social, family and structural factors have an important impact on sexual experience during the menopause (Goberna et al., 2009). The menopause must be viewed in a social context, as other factors influence women's experiences, feelings and sexuality.

Ling et al. (2008) found that the majority of their participants accepted that they experienced a decrease in sexual desire as they got older. Mishra and Kuh (2006) also reported that there was a connection between increasing age and decreases in sexual life. Similar to the result of that study, in this thesis, a few participants believed that ageing would have an impact on the reduction of their sexual desire.

Furthermore, in this thesis one woman with a vaginal prolapse avoided sexual intercourse because she was worried that she would be hurt or viewed as weird during sexual intercourse. Ghazanfarpour et al. (2018) reported that sexual desires are affected by similar urogynaecological problems such as vaginal fistula. Other studies supporting these results stated that women were embarrassed by and afraid of problems such as urinary incontinence, and therefore they avoided sexual intercourse (Rivalta et al., 2010; Lukacz et al., 2007). Looking at these results, it can be said that urogynaecological problems cause women to avoid sexual intercourse, such as vaginal prolapse.

In addition to menopausal symptoms, factors such as psychological symptoms and stress have been associated with a decrease in sexual activity (Mishra & Kuh, 2006). The findings of this thesis and those of Mishra and Kuh (2006) support the link between physiological, physical and environmental factors and changes in sexual life. We can say that decreased sexual desire affected many parts of their life, except that it is not only a symptom experienced by women. An interesting finding is the fact that women judged themselves emotionally and spiritually by guilt for this reason. Another point which I shall discuss in more detail in the following section (6.2 Women's experience of the menopause and its perceived impact on their interpersonal relationships) is that loss of sexual desire could negatively affect women's relationships with their partners.

The lack of sexual desire had a negative impact on the mood of the participants. This suggests that there might be social reasons why women feel guilty and sad. Similarly, Yang et al. (2016) reported that some menopausal women were upset about having a reduced libido or a changed sexual life. The reason for this was found to be the belief that they would not meet their husband's sexual needs. Moreover, it was stated that these women questioned their roles in their husband's life. The result of one study conducted with post-menopausal women reported that women's sexual experiences were often viewed as a duty to satisfy their partners (Feltrin & Velho, 2014). One of

the reasons why some women think this way could be the influence of socialisation and gender roles. For instance, Feltrin and Velho (2014) suggested that although women do not want to have sexual intercourse because they experience pain, they accept sexual intercourse whenever their husbands want it because they are in a submissive position towards men. They reported that women felt obliged to fulfil the wife's social role and the participants in their study blamed themselves when they could not satisfy their partners as women. This also speaks to the traditional expectations which we find in many societies of heterosexual relationships, where the man's sexual needs are prioritised (Feltrin & Velho, 2014).

Some women in the current thesis were compelled to engage in sexual intercourse with a sense of self-obligation towards the husband even though they did not want to have sexual intercourse. One woman called her situation a vicious circle because she did it involuntarily and did not enjoy it and thus did not want to do it again. While listening to this woman's experiences during the interview conversation, it was not at all difficult to understand from her voice, expression and her face that she felt deeply unhappy with this situation. This finding supports those of studies stating that some heterosexual women can continue to have sexual intercourse even when they have little desire because they see coital sex as crucial for their relationship (Ussher, Perz, & Parton, 2015; Jensen et al., 2004; Stephens, 2001).

In contrast to a decrease in sexual desire, the findings presented in this thesis show that some women experienced an increase in sexual desire, therefore supporting the findings of previous qualitative studies by Hinchliff et al. (2010) and Yang et al. (2016). The findings of this thesis have revealed that, together with menopause, there are diverse changes in the sexual life of women and this affects their lives in many ways.

In this thesis, the findings showed that there was a decrease in the frequency of sexual activity due to the loss of sexual desire of the participants, menopause symptoms, reasons related to ageing, and to their partners. Similarly, other studies have reported that the frequency of sexual intercourse decreases significantly during the menopause, especially quantitative studies (Guidozzi et al., 2017; Simon et al., 2014; Nappi et al., 2013a; Yücel & Eroğlu, 2013; Mishra & Kuh, 2006). In qualitative studies, in a few studies of this issue it was evident that women engaged in various activities to avoid sexual intercourse due to a loss of sexual desire (Hinchliff, Gott, & Wylie,

2012; Hyde et al., 2011). Similarly, in this thesis, some participants also had difficulty in saying that they did not want to have sexual intercourse with their husbands. For this reason, sometimes, just to make their husbands happy, they accepted this situation, and sometimes they tried to avoid it by producing solutions by themselves. From these results, we can say that some women lead an unsatisfactory sex life during the menopause and this makes them unhappy.

A key finding of this thesis was that some women experienced vaginal dryness which caused pain and discomfort during sexual intercourse. Previous studies have also shown that conditions such as vaginal dryness often lead to decreased sexual intercourse with a partner (Yang et al., 2016). Similarly, post-menopausal women complained of vaginal dryness in another study: it was reported that vaginal dryness caused discomfort and pain during sexual intercourse and therefore had an impact in reducing sexual desire (Kao et al., 2015). This finding indicated that women have unwanted sex and sometimes suffer for their partner's sexual pleasure. Again, the findings of this thesis show that the idea that some women should satisfy men sexually because of their gender roles is predominant. There were diverse experiences amongst the participants, which is a richness enabled by using qualitative methods. For instance, although some participants had sex just to satisfy their male partners, on the other hand, the prevailing opinion among other participants was that sex should not be just a pleasure for one partner, but an act of pleasure and happiness for both partners. The participant who stated that if sex turned into an act which only makes a man happy, it was a kind of abuse underlined that being a partner was more than just having sex together. This finding supports that of Fileborn et al. (2017) that their participants stated that the meaning of sex was not just penetrative sex. The participants did not agree with penetrative sex as real sex in heterosexual relationships. It has been reported that there were opinions that sex is considered only as sexual intercourse in society (Fileborn et al., 2017). In this thesis, it is thought that the roles formed by the social perception for women underlay the participants' view of sex as a duty. For example, some participants admitted that they felt that they had to do this as a married woman even though they did not want to have sex.

6.1.2 Women's experiences of body image and the interpersonal relationship

The participants in this thesis frequently talked about the changes in their body image and the influences which this had on their lives. Especially with the menopause, the analysis showed that the women perceived their sexual life and relationships to be affected by weight gain. However, contrary to the intensity of the information on this subject in this thesis, it has previously been dealt with in only a few studies. These studies have reported that through gaining weight, the perceived body image of women going through the menopause has a negative tendency and this attitude has negative impacts on their sexual life (Ghazanfarpour, Khadivzadeh, & Roudsari, 2018; Ussher, Perz, & Parton, 2015). Those findings reflect the findings of this thesis.

The results of a qualitative study examining the relationship between body image and sexuality for women aged in their sixties support this thesis. According to that study, there is a lifelong link between body image and sexuality. In other ways, women who are satisfied with their bodies are reported to be happier to enjoy sexuality (Foerster, 2002).

Indeed, the participants interviewed for this thesis talked a lot about their body image and changes with weight gain and the menopause, and used various ways to manage their weight, such as using diets. This means that they saw this situation as a problem and tried to solve it. In fact, when we think about the reasons for this, it is possible to say that there is an intention to adhere to the perception of beauty created by society for women, and that if you do not have a pleasant appearance, there is anxiety and fear of not being liked by men, according to the participants' accounts in this thesis.

A quantitative study of 304 menopausal women between the ages of 35 and 65 which investigated the relationship between age and body image that society expected women to have smaller body shapes even as they age (Deeks & McCabe, 2001). The impact of all these factors was the concern about women losing the partner and they focused on solving this problem.

For instance, a study exploring the ideas of women and men of similar ages about body image found that men did not express concerns about body image. Compared with women of the same age, it was observed that men had a more positive body

image (Feingold & Mazzella, 1998). In addition, in another study, it was found that female participants aged over 50, especially in the late adulthood, were very concerned about how others would evaluate their appearance, and the symptoms of depression and social anxiety were higher than women in the other age group (Davison et al., 2009).

According to the findings of this thesis, some of the women were criticized by their partners for their bodily changes and it affected them: they lost their confidence in themselves. In addition, they reported feeling less womanly and less sexy. It is an interesting idea that a slim body in the western world is equated with sexual attraction. Again, as can be understood from the findings presented here, we have explicitly analysed that a standard has been established about an 'ideal' woman's body and that women outside this standard are expected to comply with it or face bodily dissatisfaction. Ussher et al.'s (2015) participants used similar expressions to those used by the participants in this thesis. They reported that they felt less feminine and that this affected their confidence and that women felt worried that their partners did not find them attractive.

In this context, another study reported that some of the negative sexual changes of some women during the menopause were due to the change in their appearance. In addition, as women grow older, they tended to feel less attractive overall (Mansfield, Koch, & Voda, 2000). Considering that looking young is connected with sexual attraction in the cultural context and the consequences of this, these changes can have an impact on sexual desire (McHugh & Interligi, 2014).

These previous studies, however, did not appear to ask the participants about whether there was a relationship between the menopause and bodily sexual changes. In this thesis, I have explored this connection and the results are important. They show that the participants accepted that the majority of the sexual changes which they experienced were consequences of the menopause. Another issue which was particularly noteworthy was that a few participants had changed the gender of their sexual partner after the menopause. This was an unexpected finding; no similar result has been previously reported. Some of these participants now viewed themselves as bisexual.

Although there were participants who saw sexual changes as a problem, a few believed that these changes would not be a problem if they could talk to their partners and understand each other. According to some of them, sexuality was not simply expressed as coital sex. They believed that hormone deficiency in regard to sexual changes was a problem. For example, pleasure and spontaneous requests were not the same as in younger sex experience due to a lack of hormones. This means that the woman is not ready for sexual intercourse spontaneously and needs to devise a tactic for sexual intercourse because of different thoughts or other factors.

6.2 Women's experience of the menopause and its perceived impact on their interpersonal relationship

The findings clearly showed that interpersonal relationships were significant for the women and that the features of marital and committed relationships had a great impact on shaping women's quality of life, their psychology and well-being.

6.2.1 Does the menopause affect the relationship?

The participants said that their relationship was deeply affected by the experience of the menopause, which shows that the menopause was not only a physical experience in their lives but also an interpersonal one, as their relationships were affected. In this period, the woman remained in a position to fight against intense emotions and many problems. All the changes and negativities experienced were reflected in their sexual life and their relationship with their partner. These results show that we need to pay attention to the importance of not only the physical dimension but also the emotional and relationship dimensions of the menopause.

The thesis findings have shown that all of the participants believed that the menopause had a great impact on their interpersonal relationship. Caico (2013) conducted a quantitative study to determine whether there is a relationship between menopausal symptoms and marriage or long-term relationships, and found a connection between menopausal experiences and marital relationships. In other words, it has been determined that the interpersonal relationships of women who experience the menopause are affected (Caico, 2013). In another quantitative study conducted with middle-aged women, sexual pleasure, stress, marriage satisfaction, quality of

marriage and menopausal symptomatology were all found to be related (Fielder & Kurpius, 2005). The results of these studies are consistent with the findings presented in this thesis. Furthermore, this thesis findings support the idea that the menopause can affect the relationship and that the relationship can affect women's experiences of the menopause.

According to the findings presented in this thesis, both the physical and emotional factors of the menopause can affect the interpersonal relationships of some women. Some previous studies have reported a significant positive correlation between the severity of menopausal symptoms and sexual dysfunction (Nazarpour, Simbar, Tehrani, et al., 2018; Ornat et al., 2013; Cabral et al., 2012). For instance, it was found that menopausal symptoms can have a major impact on sexual function in a study of 405 post-menopausal women to investigate the relationship between the severity of menopausal symptoms and sexual function (Nazarpour, Simbar, Tehrani, et al., 2018). Among the participants in this current thesis were women who thought that the severity of menopausal symptoms was more negative with their male partner. In other words, it can be said that there is a connection between the influence of the severity of menopause symptoms on the relationship. Furthermore, Minkin et al. (2015) found a potential relationship between the prevalence of post-menopausal symptoms and the influence of these symptoms on relationships. A study conducted with 1805 European women reported that women who had not experienced menopausal symptoms such as lack of sex drive, vaginal dryness or mood changes had the highest sexual satisfaction (Nappi & Nijland, 2008).

First, with the lack of sexual desire reported in women's accounts in this thesis, sexual changes often became a problem for interpersonal relationships and they thought that this was difficult to solve. The lack of sexual desire was a really difficult situation for the women and therefore they believed that their relationship was emotionally deeply affected. Although there was a relationship of love and peace between the men and women, there was one participant who said that there was a gap between her and her husband due to sexual changes such as her loss of sexual desire. Although there was a gap between the couple, what she meant was not clear, but what she talked about during the whole interview was that the bond between a couple is like a broken one when sexuality decreases. This might mean that one of the cornerstones of the

relationship was seen as not only sexual intercourse but also the intimacy and bonding which sex enables.

6.2.2 How do menopause symptoms impact on the relationship

The findings presented in this thesis have shown that the impact of menopause symptoms on their relationship was negative for all of the participants. For example, if a woman had hot flushes, she did not want anyone to touch her and did not even want to think about sex. These results are similar to those of other studies which have found that menopausal symptoms such as vaginal dryness, hot flushes and night sweats negatively affected women's relationships (Minkin, Reiter, & Maamari, 2015) and somatic symptoms such as hot flushes were linked to difficulties in sexual intercourse (Mishra & Kuh, 2006). Most of the participants in a previous qualitative study reported that they experienced a decrease in sexual desires due to menopause symptoms such as hot flushes (Ling, Wong, & Ho, 2008). These findings show that women without physical well-being may want to stay away from sexuality and that menopausal symptoms can directly affect the relationship and sexuality.

Other studies have reported that women who experience vaginal dryness during the menopause may have poor sexual functionality, including a decrease in sex life and problems with intercourse (Mishra & Kuh, 2006). In particular, vaginal symptoms affect the physical relationship between post-menopausal women and their male partners (Minkin, Reiter, & Maamari, 2015; Guidoizzi et al., 2017; Domoney et al., 2013). A survey conducted in the UK reported that most of the participants avoided sexual intercourse due to vaginal discomfort, and about 20% of the respondents were emotionally distanced from their partner (Domoney et al., 2013).

It is noteworthy that this finding is consistent with those reported in this thesis because the participants frequently stated that their sexual activity was negatively affected due to the problems which they experienced as a consequence of vaginal dryness. These outcomes are valuable for healthcare workers to take into account treatments such as intravaginal oestrogen or moisturizers (Mishra & Kuh, 2006; Barrett-Connor, Grady, & Stefanick, 2005; Bachmann & Leiblum, 2004). I shall return to this point when I discuss the implications of my findings.

In this thesis, the participants were usually disinterested in sex because of symptoms which sapped their energy, such as sleep problems and fatigue. In addition, they believed that these symptoms negatively affected their relationship with their partner. Previous studies have reported that insufficient sleep and sleep disorders in peri- and post-menopausal women are high in frequency (Minkin, Reiter, & Maamari, 2015; Nappi & Nijland, 2008; Landis & Moe, 2004) and cause important health problems (Landis & Moe, 2004). However, I was unable to find any study on how the sleep problem experienced during the menopause has an impact on the relationships of women. It can therefore be said that more research is needed on the impact of sleep-related problems in menopausal women on their relationships. In the implication chapter, explanations are given on this subject.

The findings presented in the previous chapter provide evidence that some women thought that the menopause caused problems in their relationships due to emotional changes such as mood swings and irritability. These women criticized themselves believing that their behaviour was unpleasant. Some participants were of the opinion that their partners did not understand them and this negatively affected their relationship. A previous qualitative study conducted by Nosek et al. (2012) also found that women who reported mood swings were concerned that it would negatively affect their relationships. These findings suggest that is especially important for men to understand that the symptoms which occur outside the control of women can be caused by the menopause in order to maintain a healthy relationship. I shall return to this point when I discuss the implications of the findings.

6.2.3 Feelings and concern about the relationship

Due to all these menopause symptoms, the findings showed that women felt guilty in many ways and faced many negative emotions. Another important detail which draws attention is that some women were in fear, stress and anxiety of losing their partner and feared that their partner would have a relationship with another woman especially because his wife's menopausal symptoms were causing unmet sexual needs. These findings of this thesis are consistent with the literature on the anxiety of menopausal women about losing their husbands and post-menopausal women being concerned that their partners might have extramarital relationships in order to satisfy unmet

sexual needs (Yang et al., 2016; Ling, Wong, & Ho, 2008) and this has caused guilt and frustration in post-menopausal women (Yang et al., 2016).

Some participants even harshly criticized themselves, stating that even if their husband left, they thought that they would find him to be right. These findings show that both the physical and the mental symptoms which women experience during the menopause cause them to blame themselves. Some participants emphasized that they had a good relationship with their partner or husband before the menopause, which shows clearly how the menopause had badly changed their interpersonal relationship. The fear that their husband might have an affair with another woman indicates that women's trust in themselves and their husbands has decreased and they worried that their relationship could end at any time.

In addition, some women thought that their partners would no longer like them because they thought they were no longer young and could not satisfy their partners sexually. They thought that menopausal women did not look sexy and attractive, and the most striking detail was that although they did not want to have a child, not having the chance of having a child had a negative impact on their relationship. This demonstrates that the woman sees as a deficiency that she can no longer bear children. As mentioned in the Background chapter and in the discussion above, social expectations of gender and especially of women as nurturers and mothers can have a negative impact on women in the menopause (Obermeyer, 2000; Bachmann, 1995).

It was seen in the findings that the menopause was one of the most important reasons for some women ending their relationship. The participants who stated that the changes which they went through with the menopause contributed to the end of their relationship once again underlined the importance of the reflection of the menopause on the relationship. This discourse was not observed in the literature. The reason for this might be that previous studies did not go deeply into the issue of how the menopause affects the relationship of women. The findings presented in this thesis, however, have identified the necessity of addressing this issue because women going through the menopause experience perhaps the greatest stress in relational dimensions. It is also important for both their physical and their mental health to support them on this issue.

It can also be said that from the results presented here and those reported in the literature, the gender role has an influence of women because some women stated that they had a duty as a woman in regard to their partner and that not fulfilling this duty created a sense of deficiency in them. Although I had initially thought that gender roles would not have an impact in western society, I observed that some of the statements made by the women on this issue were similar to attitudes in other European countries and in countries such as China and Iran. I think that this is the influence of women assuming universal social roles which occur as a result of gender discrimination not just in one society but in many societies (Moghasemi et al., 2018; Yang et al., 2016; Ling, Wong & Ho, 2008).

6.2.4 The importance of male partners/husbands support for menopausal women and their understanding of the menopause

The findings showed that for women during the menopause, their partner's understanding and tolerance had a positive impact on them. It can be said that when women's menopausal symptoms are known by their partner or husband and that women are supported by them, this is reflected positively in their relationship. For instance, when a woman was very angry or had hot flushes, she felt better when her male partner acted in a way that calmed down and softened the atmosphere between them. One of the most important issues is that when a woman does not want sexual intercourse due to lack of sexual desire, vaginal dryness, pain or bleeding, some participants stated that the man's understanding and not applying pressure on the woman also had a positive impact on the relationship. In addition, the findings presented in this thesis indicate that when the male partner is understanding and supportive, it can ease the difficult experience of menopausal symptoms for the women. Some of the participants also said that their male partners did not fully know about or understand menopause and therefore did not understand the symptoms and problems which they were experiencing and did not support them. They thought that men see menopause as simply losing the natural ability to have children and they emphasized that men should be more open to talking about this issue. All of these findings indicate that some participants thought that men do not understand the menopause and that they therefore have trouble getting support from them.

It has been understood from the thesis findings that the man's lack of understanding and his negative attitude towards the symptoms experienced in the menopause cause the woman to feel worse and increase the severity of the men's responses. Anxiety and depression particularly increased the severity of their states, and all of these factors negatively affected some women both mentally and physically. As a result, the relationship between men and women was naturally damaged and some women had to end their relationship for these reasons. All these results suggest that men should be aware of the signs and symptoms of the menopause and that it is important for them to support their wife or partner during this period. This also points out the importance of including men in healthcare services for women during the menopause and offering a variety of training and services for them. In the implications chapter, explanations will be given on this subject.

Although the menopause is not a disease but a transitional stage in a woman's life, it has important and powerful health effects (Fielder & Kurpius, 2005). Research has also shown a connection between relationship quality and menopausal symptoms. For instance, working with 224 women with middle-age menopause experience, Fielder and Kurpius (2005) found that those women in dissatisfying marriages, that is, women who had less support from their partner and had more problems, experienced more menopausal symptoms than women in satisfying marriages. On the other hand, women with a more supportive partner reported experiencing fewer menopausal symptoms (Fielder & Kurpius, 2005). In another study, women with more marital anger and hostility and lower marital satisfaction experienced more menopausal symptoms such as sleep problems and vasomotor problems (Kurpius, Nicpon, & Maresh, 2001). These results are consistent with those reported in this current thesis. Although it is not easy to identify the direct cause and effect in the first place (Kopala & Keitel, 2003), it is understood from the previous studies and the findings in this thesis that relationship quality and partner support have an impact on a woman's menopause experience. Marriage relationship quality was stated to be a significant contextual factor which should be taken into account when examining women's lives (Fielder & Kurpius, 2005).

Considering it fully, we cannot say that menopausal symptoms are only due to biological and hormonal changes. We also see the importance of a close relationship

with menopausal symptoms. Fielder and Kurpui (2005) reported that in order to understand the menopause experience, it is necessary to consider the contextual factors of the marital relationship. It was pointed out that there is also an interaction between sexual satisfaction and marital satisfaction. Sexual satisfaction, stress, marital satisfaction, marital quality, and menopausal symptomatology were found to be interrelated. Based on this result and the findings presented in this thesis show the importance of the impacts of both physical and mental changes in the menopause on the relationship and the influence of the quality of the relationship on the menopause. For these reasons, it is important to support women in the menopause and in middle age in relational dimensions.

On the other hand, every male-female relationship is different and at this point, it is difficult to distinguish whether the relationship affects menopausal symptoms or menopausal symptoms affect the relationship (Avis et al., 2005). If we look at this thought, it may be difficult to distinguish, but I argue that there is a mutually interactive relationship between menopause symptoms and relationship. This does not alter the fact that the relationship in a woman's life should be further supported during the menopause.

Some studies have reported women to be concerned about the reaction of their spouse to the menopause, and their main concern is that their partners attitude is not related to the sexual distress of the partner, to their spouse seeing them as unsexy and useless. They saw this situation as a threat to the continuity of the family (Moghasemi et al., 2018). According to a survey on the effect of partners in alleviating menopausal symptoms in women age 45 to 55, 100% of men did not talk to their wives about menopause problems and it was reported that they did not support them in their difficult times (Kowalczyk et al., 2008)

Caçapava et al. (2016) studied male perception, experience and attitude towards women during menopause and found that those men who better understood the changes which women experience during the menopause provided more emotional support to their wives/partners. In addition, the more the men learned about the symptoms of the menopause, the more they tended to respect the woman who needs to be alone, or show more attention to them when needed, and display more supportive and positive behaviour. The quality of their marriage relationship therefore

increased. Men also had difficulty understanding the physical and emotional symptoms of menopause because of their lack of knowledge about the menopause and therefore had trouble coping (Caçapava Rodolpho et al., 2016).

I argue that these results once again demonstrate the importance of providing access to information on the menopause in order to cope with the negative impacts of the changes in menopause between couples. As suggested by Caçapava et al. (2016), these findings increase the importance of correct explanations to determine how husbands can offer support to their wives. For this reason, healthcare providers play an important role. It might also be beneficial to provide women and husbands with health education on this subject (Caçapava Rodolpho et al., 2016; Lindh-Åstrand et al., 2007). I shall return to this point in the Implications chapter.

The findings show that some participants felt compelled to have sex. They confessed that they felt that they saw this as a responsibility, a kind of duty towards their partners, especially their husbands. They believed that if there was no sex, the relationship would suffer. In contrast, one participant admitted that this feeling changed as she got older, and said that she felt that she no longer felt an obligation. Considering these findings, we can say that women basically had to continue having sex in order not to disturb their relations with their husband or partner and their family order. We may say that it is even more difficult for them to have this feeling, especially with the symptoms which they experience during the menopause. For example, even when they experienced vaginal dryness, sexual reluctance or severe hot flushes, they were obliged to fulfil their sex responsibilities to their husbands, forcing them to do something they did not want. This can cause these women to be harmed both physically and spiritually.

Considering the underlying reasons for such feelings of women, it is possible to think that it is due to the social roles of women and social pressure within a male-dominated society. Otherwise, why would women have to do something they do not want to do just to keep the family order going and to please the men? For example, for some women, it might be sufficient to just to have a hug or to establish emotional bonding without sex (Wood, Mansfield, & Koch, 2007). As explained in the previous section on feelings and worries about the relationship, we can say that the woman's fear of losing her partner also affects this situation.

6.3. Working it out: trying to manage the sexual changes of the menopause

6.3.1 Biomedical methods: to use or not to use

In general, the participants' unwillingness to use medication and the desire to cope naturally with the sexual changes which occur in the menopause deterred them from the idea of using HRT or any medical assistance for their sexual changes. The common idea of staying away from medication and their desire to find solutions to their symptoms in a natural way was expressed many times. The methods which women called 'natural' meant diet, alternative medicine, herbal products, clothes or sports.

The participants who has used HRT gave their reasons for starting HRT as vaginal bleeding and intolerable vasomotor menopausal symptoms. Although the reason for their use of HRT was not the sexual changes which they experienced, they had seen that the use of HRT is additionally beneficial on symptoms such as the lack of sexual desire. On the other hand, a qualitative study conducted by Yang et al. (2016) found that the reason for using HRT by their participants was to reduce physical discomfort and to improve their sexual relations with their partners. However, only physical symptoms were the reasons for participants in this current thesis to use HRT.

The fact that the participants did not consider using HRT for sexual changes indicates that they did not know enough about the benefits of HRT because the participants who did use HRT for their bleeding or severe menopausal symptoms did not consider using it for sexual changes. Although this is a situation in which not only women but also healthcare providers and GPs have an influence, the participants felt that they did not get the support they wanted on HRT as well as on many other issues from their GP. Barriers to seeking and receiving medical help for middle-aged sexual difficulties are clearly related to both psychological and social factors. For example, the reluctance of older people to seek medical help may be due to the low tendency of doctors to ask questions about patients' sexual functions and to give appropriate advice (Hinchliff & Gott, 2011).

In this context, the participants tried to solve their problems on their own, as they were worried about the sensitivity and confidentiality of the issue and the reactions it would

receive from their immediate environment such as friends and family members, as they could not get enough support from healthcare professionals.

Some of the participants thought about whether they should use medication and apply for professional help or not for a long time because they did not have sexual desire for a long time, and they also judged themselves over this. This actually shows that there is a lack of information on how and from whom to seek help for the sexual changes which a woman experiences during the menopause, especially due to a lack of sexual desire. I shall discuss this in more depth in the implications chapter.

The thesis identified that some participants had used lubrication to get rid of the pain which they experienced during sexual intercourse. The fact that the participants had a more positive approach to using lubrication might have been due to the fact that they thought of lubrication as an alternative medicine rather than as a medication because there were participants who were using lubrication but not using HRT or who were against using any medication. From the findings of this thesis, it can be said that women actually have a positive tendency towards using lubrication. Furthermore, it shows that women can use non-medical methods to resolve the difficulties which they experience for the continuation of sexual intercourse.

Some studies made similar findings, with participants using creams or lubricants to solve the problem of the change in vaginal lubrication (Yang et al., 2016; Hyde et al., 2011; Dillaway, 2005). Ling et al. (2008) stated that the hormonal and physiological changes experienced can cause a decrease in sexual desire just like the problem of lubrication.

Pain due to vaginal dryness and to the lack of sexual desire may be associated with each other. A lack of sexual desire can occur due to pain, or sexual pain can occur due to insufficient lubrication. In a qualitative study supporting this view, a similar issue was addressed and it was found that participants with vulvar pain and loss of sexual desire had very similar experiences in their emerging sexual negotiations. This brings to mind the thought that it might be due to the overlapping of these two problems. Hinchliff, Gott and Wylie's (2012) findings showed the awareness of the uncertain boundaries between these two different sexual problems, and they searched for ways to reconsider the sexual relations of heterosexual women in the context of close interpersonal relationships (Hinchliff, Gott, & Wylie, 2012).

Their findings showed that some participants admitted that preceding sexual intercourse, their partner or husband did not like using lubrication because it was disruptive before intercourse even if it had a generally beneficial effect. Among the reasons behind it being disruptive were the necessity of applying a pre-sexual intercourse procedure and the delay caused a negative emotion. There was also the necessity of sometimes interrupting sexual intercourse in order to re-apply the lubrication. The participants had started using lubrication without the advice or support of any healthcare professional, which could mean that they did not have adequate support from a healthcare provider. Alternatively, it might mean that they learned about lubrication from other sources such as friends and the media.

6.3.2 Alternative medicine and other methods to help deal with sexual changes

These thesis findings showed that the participants frequently used alternative medicine(s) to manage their menopause symptoms. However, the striking point was that the main reason why they preferred herbal remedies and alternative medicine was not because of the sexual changes they experienced, but because of the unbearable menopausal symptoms which they experienced. Only one woman had used a herbal remedy called maca powder for her lack of sexual desire. This product was used to solve the problem of the lack of sexual desire by causing an increase in sexual desire and she believed that she had benefited from it. Women in the menopause use maca powder to calm themselves down (Rubinstein, 2013). A systematic review of studies on the use of maca powder among menopausal women concluded that there was not enough evidence to say exactly whether maca powder has any benefit for menopausal symptoms (Lee et al., 2011).

In order to overcome the sexual changes experienced by the participants, they had used methods such as pelvic floor exercises, eating well, staying fit, changing their appearance, having their hair cut, and wearing beautiful dresses. By working on their appearance and body, the participants tried to increase their partners' desire and also to increase their own sexual desire and self-confidence. In addition, they resorted to these methods to alleviate or eliminate the symptoms of the menopause.

With ageing, some people can experience a mental and physical decline. Exercise helps to preserve muscle tone and energy. The participants who searched for a solution to their sexual changes by exercising stated that exercise reflected positively on their sexual lives, similar to the results reported by Yang et al. (2016). It was thought by the participants in Yang et al.'s (2016) study that exercising helped them to know how to control their body muscles which allowed them to continue enjoying sex after the menopause. This means that being physically healthy is important for increasing women's physical strength and sexual health being by exercising.

Some participants stated that they felt better and increased their desire to have sex after adopting a healthy diet. In fact, this analysis may prove that the healthy diet of women during menopause positively affects them. The literature review showed that no previous study has been carried out on the impact of healthy eating habits during the menopause on the sex life of women. By eating a healthy diet, the fatigue often experienced during the menopause can be prevented and women can feel more energetic, which can have a positive impact on sexual desire. This is because the symptoms of the menopause can make women sleep deprived, feel tired, and abstain from sexual activity as it lowers their energy. As can be understood from this finding, health should be considered as a whole.

Some of the participants admitted that they had tried to resolve the issue of it taking longer to reach orgasm by thinking what one of them called 'wonderful things' (we can assume that she meant sexual fantasies) and that they were trying to prolong sexual intercourse in order to reach a climax. This can be regarded as a solution developed by the woman herself to increase her sexual satisfaction. A study has shown that the most important difference between men's and women's fantasies was that men's fantasies were more explicit whereas women's fantasies were more emotional and romantic; it was also found that men have more than one partner in their fantasies (Zurbriggen & Yost, 2004). A study conducted with women between the ages of 40 and 60 found that the frequency of sexual fantasy was not affected by the menopause status (Lo & Kok, 2013).

As has already been discussed, the findings show that one participant did not feel sexy with the weight gained during the menopause and that losing weight was seen as a solution to the negative reactions which she received from her partner. Thinking about

losing weight and being thinner in order to look more sexy again shows the visuality and body image perception created for women. The change in appearance associated not just with the menopause but also with the impact of age and the weight gain made women feel compelled to lose weight because of the perception that men do not like fat women and regard them as not sexy. The perception that an overweight woman is not sexy and the belief that appearance is important to men can make women try to lose weight against their will just to maintain their relationship. These findings support those of a study in Iran (Moghasemi et al., 2018) which reported that women often tried to change their external appearance to combat middle-aged sexual changes. These changes were achieved by changing clothes, make-up and aesthetic treatments such as liposuction. These results and the current findings indicate that women try to conform to the social perception of beauty by changing their external appearance or that men feel that they have to comply with the idea that women's physical appearance should be good.

In the quantitative part study by Rockliffe-Fidler and Kiemle (2003) found no significant relationship between body satisfaction score and sexuality and sexual function scores. In the qualitative part of their study, some women stated that they thought that weight affected them both sexually and emotionally. In that study, the women revealed that they thought that weight puts men off and they did not feel well. Although it does not seem to be related to the sexual reflection of the weight gain using quantitative methods in the life of women, it is an invisible part of this issue together with the results in the qualitative section and it emphasizes the importance of revealing it.

The findings show that some of the participants did not experience any problems such as a lack of sexual desire, did not experience any sexual changes during the menopause, and therefore did not need any solution. They believed that if there was any problem, the best solution was to talk to their partner and that it was important not to be ignored as if the problems were absent. The findings show that for women, being in communication with the partner means that they could solve many problems.

It has sometimes been seen that the lack of sexual desire experienced in the menopause does not actually cause a problem in the relationship because with the simultaneous ageing of the husband, a balance has actually been achieved because neither of them has much energy for sexual intercourse. From this finding, it can be

concluded that the age balance between men and women is also important for sexual relationships. Studies on this subject have shown that factors which might affect sexual life such as the age of their partners and whether they have health problems (Ghazanfarpour, Khadivzadeh, & Roudsari, 2018; Ling, Wong, & Ho, 2008) should be taken into account. It has been shown that couples who have been together for a long time and couples who say that they know each other very well find it easy to solve problems such as sexual reluctance.

There was only one participant who stated that she had used various sex toys to increase mainly her husband's sexual desire and her own as well and to bring excitement to their sexual relationship. The fact that the participant stated that this was common in society but that people did not talk about it showed that this issue was embarrassing for women and should not be discussed. The main reason for the sex toys which that couple used was that it was not related to the woman, but because of the lack of sexual desire and erection problems from which her husband suffered. In a study conducted among women with cancer-related menopause, it was stated that sex toys may be useful in increasing sexual satisfaction among strategies other than coital sex (Ussher, Perz, & Parton, 2015).

Another qualitative study found that some of the women who could not have sexual intercourse as a result of their partner's erectile dysfunction mentioned the importance of cuddling (Gott & Hinchliff, 2003). In the current study, however, it was found that one woman's husband had had a lack of sexual desire and erectile dysfunction for many years and that he did not indulge in hugging or kissing, and therefore she could no longer bear this situation. On the other hand, there were participants who had started wearing sexy underwear for the first time after the menopause for their partners and themselves. The reason for the increased sexual desire and the first time they used sexy clothes which they had never previously needed in their relationships can be regarded as a solution to the sexual changes which they experienced during the menopause.

That participant (Nancy) admitted that she had not bought these clothes for herself, but for her husband's pleasure. This clearly shows the idea that the woman should satisfy her husband sexually. The fact that Nancy shared such special knowledge with me with both indecision and shame was clearly evident from her body language.

These findings show that topics of this kind are not seen by women as things which can be comfortably discussed and shared with other people.

There was only one participant who said that she was masturbating. Considering why the other participants never mentioned masturbation, it might be that they were not open to talking about this topic as it is something which they would see when watching an adult video, and they felt embarrassed to talk about it.

Avis et al. (2009) found an increase in masturbation in the early peri-menopause period but a decrease during the post-menopause period. It was suggested that the reason for this is that there is an increase in painful sexual intercourse during the peri-menopause period and that the decrease in the post-menopausal period was a consequence of the decrease in sexual desire.

When the topic of adult films was brought up, the participants who showed rapid reactions such as embarrassment and suddenly denying that they had watched them clearly showed that they were embarrassed to talk about it. In order to increase the lack of sexual desire, the fact that the participants expressly stated that they did not resort to these methods clearly showed that watching such movies by women is shameful and embarrassing. In Yang et al.'s (2016) qualitative study with Taiwanese menopausal women, it was stated that some participants watched adult movies to stimulate their desire for sex, alleviate discomfort during sex, learn about alternative sex positions, and increase foreplay.

When asked how they coped with the sexual changes which they were experiencing and what methods they had used to resolve them, some women said that they were not able to directly tell their husband or partner that they did not want sexual intercourse as they did not want to upset him. They sought various excuses (e.g. quickly got out of bed and was busy with other things such as ironing, headache) to avoid this when it comes to sexual intimacy. In this way, the woman tried to make her partner think that she was busy and that the reason why she did not want sexual intercourse was not her. With the inability to say 'No', we see that they could not express themselves sufficiently so they needed another reason not to do something they did not want to do by telling such lies. This shows that a woman does not have the luxury of saying 'I do not have to do something that I don't want to do'.

This finding is similar to that of Hinchliff, Gott, & Wylie (2012) that women with similar complaints tried to avoid sexual intercourse by keeping busy and pretending to be tired. Like the participants in this thesis, women in that study did not want their husbands to feel rejected. This could also mean that women put their husbands' needs in front of their own. Starting from this point, they tried to manage to stay away from sexual contact by applying various attempts. It has been stated that the act of mental planning of sexual contact means that sex is surrounded by mechanical terms (Hinchliff, Gott, & Wylie, 2012).

Furthermore, quantitative studies have reported that avoiding intimacy is a common practice during the menopause. For example, it has been reported that avoidance of intimacy occurs in 76.2% in three hundred and twenty-five post-menopausal women (Chedraui et al., 2007) and 69% in five hundred post-menopausal women (Domoney et al., 2013). These results show that it is obvious that this situation should be taken seriously and should be emphasized more. Wood et al. (2007) showed that women who are dissatisfied with sexual intercourse, in addition to the causes of pain or sexual reluctance during intercourse, can avoid sexual intercourse. Women should not have to have sexual intercourse unless it is enjoyable and satisfactory, and this should be presented to them as a legitimate option (Wood, Mansfield, & Koch, 2007). Apart from the unwillingness of women to avoid sexual intercourse, they should not need any other reason.

6.4 Contribution to knowledge

The findings presented in this thesis are important in terms of increasing knowledge and contributing to the literature on post-menopausal women's experiences of the menopause and the perceived impact which the menopause can have on their interpersonal relationships and intimacy, and the methods which they use to cope. In this section, I shall explain how the thesis has achieved its aim and objectives. By considering the contribution to this knowledge in two different ways, both the theoretical and the methodological contributions are presented in this section.

6.4.1 Theoretical contribution to knowledge

The theoretical contributions this thesis makes to knowledge are multifaceted. I discuss them below by considering the gaps which were identified in the Literature Review and Discussion chapters, and according to the order in which the Findings were presented.

First, I argue that this thesis has furthered our knowledge about a biopsychosocial perspective of women and sexuality what was experienced by the participants about the menopause. It has done this by taking a holistic approach to the menopause. Findings are important in terms of paying attention to what was experienced by the participants about the menopause and whether their experiences are related to each other.

As was noted in the Literature Review, there have been few qualitative studies focusing on the sex lives of women after the menopause and their results were also mixed. In this thesis, the findings have been presented as plainly, concisely, and clearly as possible . Also, a large amount of relevant of data was obtained, adding to the body of evidence on sexual changes during the menopause. For this reason, this thesis, unlike previous studies, contributes to a clearer understanding of the experiences of women by presenting in-depth data.

Furthermore, this thesis has provided a deeper understanding of women's experiences of sexual changes, its impact on relationship and their coping methods by making the limited points in the findings of other the studies included in the literature review . For example, data on the lack of sexual desire in women during the menopause have been included in a few qualitative studies (Moghasemi et al., 2018; Yang et al., 2016; Hyde et al., 2011; Ling, Wong, & Ho, 2008). In mostly quantitative studies, however, the sexual desire levels experienced by women were included as numbers and percentages (Yücel & Eroğlu, 2013; Moghassemi, Ziaei, & Haidari, 2011; Nappi & Nijland, 2008, Nobre & Pinto-Gouveia, 2006). Taken together with the findings of this thesis, although the data show that the change in sexual desire generally decreases, this thesis shows that there was no change in the sexual desire levels of some menopausal women, whereas others experienced an increase in their sexual desire. This contributes to the women's health and sex research literature in terms of

showing that there may be differences when it comes to sexual desire, contrary to the predominant view in the biomedical literature that sexual desire decreases with the menopause.

Furthermore, as far as I am aware that there is no information in the qualitative studies literature about how long the low sexual desire experienced by women persists. The results of this thesis also show that it is important to reveal that it might take years for women who have lost their sexual desire to experience this situation. This information is important in terms of showing that women may have to cope with this problem since the decrease in sexual desire lasts for years. This thesis contributes to the literature also in terms of showing the menopause in its social and interpersonal contexts, and the mental and physical impact of menopause on the sexual lives of the women.

Additionally, the findings obtained on women's weight, the change in their bodies and how it affects relationship with their partner are unique and rarely reported in the literature. The findings presented about how the weight gained in menopause also becomes a problem between spouses with the influence of age and the experiences of the participants in coping with this situation contribute to filling the gap in the literature. These findings, bring an alternative perspective on the reflection of weight gain in menopause on the relationship between men and women by moving beyond the perception of personal beauty.

The participants were asked whether there was a connection between the sexual changes experienced with the menopause. From the data obtained from their responses, the belief that the sexual changes of the participants were associated with the menopause is important in that no similar information has been found in the literature. Having this knowledge is of great importance in terms of why we should consider women's thoughts. When we look at the literature, there are no data indicating that there is no change in sexual partner difference after the menopause. The results of this study have therefore contributed something new to the literature. This finding is important because it can be useful to know that these and similar situations can occur in the approaches to women undergoing the menopause and to conduct research accordingly.

The participants were asked whether or not sexual changes were a problem, and together with the findings obtained, the perspectives of the women are presented in

this thesis. Knowing the perspectives of women can be beneficial for the services that will be offered to them. This information was not found in any previous studies. The findings of this study clearly demonstrated what methods women use while struggling with sexual changes. In previous studies, there are serious deficiencies and inadequate findings in this area.

The findings of this thesis have provided a new perspective to women's health, menopause and sex research literature by showing that the participants believed that the impact of the menopause does have a close link with their relationships. In some quantitative studies, it was mentioned superficially that there is a link between menopausal symptoms and women's relationships with their partners, but this link was not directly addressed in qualitative studies. Knowing this is important in terms of keeping in mind the support needed by women who believe that the menopause has a close impact on relationships.

Although the findings of this thesis show how women use coping methods for their menopausal symptoms, they also reveal the differences in coping methods used for sexual changes compared with menopausal symptoms in many respects. For example, the fact that the participants did not seek help for their sexual problems by resorting to methods such as HRT or alternative medicine for menopausal symptoms clearly showed that women should be supported in this regard. This finding contributes to the literature as a good example of research in terms of showing the differences between women's responses to the physical impacts of the menopause and sexual changes at the point of seeking help or solving problems.

I believe that in terms of showing that the impact of the menopause on women's life is interrelated, this thesis contributes to the literature as an important source of information. It was helpful to talk to participants about the physical and psychological impacts of the menopause and to establish connections between them in order to see the influences of the sexual changes which they experienced and of the menopause in their relationships.

Furthermore, this thesis presents the findings under various headings. Presenting the findings under various headings is important in terms of facilitating the transfer and clarity of the findings to the reader. These findings will make an important contribution to the literature in terms of showing both the approach of women to the menopause

and the knowledge which they have and, in this regard, in which subjects women undergoing the menopause should be supported and in which subjects they have deficiencies of support. Although this thesis was conducted with a small group of post-menopausal women, it contributes to the knowledge by revealing the diversity, similarities and differences of the experiences of the women in this group.

6.4.2 Methodological contribution to knowledge

Although it is known that the use of IPA in research on sexuality is common, I have not come across its use in any study involving sexuality and relationships with menopausal women. I have shown in this thesis how IPA can be used to explore post-menopausal women's experiences of the menopause and the perceived impact which the menopause can have on their interpersonal relationships and intimacy, and the coping methods which they have used.

The use of IPA has played an important role in making it easier for me as a researcher to understand the women's sexual and interpersonal relationship experiences, their deeply personal experiences, and how they are coping with these experiences. The IPA methodology has also provided convenience in making their voices heard, especially since the menopause should not be understood only from a biological perspective.

Another contribution which came from using IPA is that the small sample contributed to a great extent to making the level of analysis as detailed as possible. This allowed me to focus on women's experiences and include even non-verbal communication expressions in the analysis, as well as every word which they uttered. It also played an important role in revealing the relationships and ties between women's experiences. This helped the analysis to be more holistic. In this way, it was beneficial for the findings obtained to reflect the participants at a high level to reflect the truth and to understand the meanings correctly.

When giving a critique of previous studies in the literature review, I emphasized the limitations on the sample. When I think about these limitations again, it is important that this thesis exceeds the limitations of other studies in terms of the sample. In other words, participants were excluded by many studies' limitations such as those who had applied to any health institution, participated in a previous study, were in different

menopause stages, were only married or single, and the age difference between the participants was very wide. This shows the contribution of the current study on the basis of the sample to the literature.

6.5 Reflexivity

Reflexivity is a complementary part of ensuring the transparency and quality of qualitative research. Reflexivity is defined as the process of critical self-reflection about the individual as a researcher (preconceptions, prejudices, preferences) and the research relationship (the relationship between the researcher and the respondents and how this relationship influences the participants' answers to the questions) (Korstjens & Moser, 2018). Qualitative research can change the researcher in many ways. Through reflexivity, researchers confirm the changes which occur in themselves as a result of the research process and how these changes are reflected in the research process. Although reflexivity represents a new chapter in qualitative research, it is not yet sufficiently defined and is difficult to understand. The value of reflexivity has been largely ignored (Palaganas et al., 2017).

6.5.1 Reflexivity and recruitment

After reading the participant information sheet, I was frankly worried about the negative reaction of the volunteers when they learned that the thesis would explore the impact of the menopause on their lives and the changes which they had experienced. As I explained in the Methods chapter, some volunteers stated that after reading the participant information sheet, they gave up on the subject of the thesis because it was too sensitive and personal for them. Although this supported my initial concern, my worries decreased as I found volunteers to be participants.

As described in the Methods chapter, 40 women volunteered to take part in the thesis. I tried to ignore my preconceived notions as much as possible while looking for participants because finding participants was difficult for me and I did not want to cause any bias. I only considered the inclusion and exclusion criteria in my thesis. Other than that, I did not enter into deeper distinctions such as women's choice of clothing, education level or social status. Since I could not have an opportunity to meet face-to-face with the participants until the agreed interview date, I did not have a chance to

form an opinion about them beforehand. I can therefore say that I approached the participants with few preconceived notions.

In the Methods chapter, I explained that some women were initially willing to participate but I could not subsequently reach them, or that some women decided not to participate for various reasons. Honestly, until the eventual meeting, I was anxious that the participants who were willing to participate and wanted detailed information about further study would eventually want to give up. I did not have the opportunity to ask why the women who were willing at first but did not respond to me afterwards, but some of the women who responded to my e-mails did give their reasons for not wanting to participate.

Although some women were willing to participate, I did not have a chance to ask why they changed their minds and stopped participating in the study later on, because some women did not respond to my e-mails and messages. When I guessed the reasons for the women who gave up participating in the research and never responded, I assumed that the first reason was that they did not actually want to talk about sexuality and some of them did explain that they did not want to talk about their sexuality, which frankly supported my concerns and caused me to ask myself whether my being an international researcher myself had an impact on this. On the other hand, this situation was surprising for me, as I had thought that British people would be more free to talk about sexuality.

6.5.2 Reflexivity and data collection

At the beginning of the data collection, I was concerned about whether the participants would share with me their sexual experiences at the menopause. The main reason why I thought this way was because I was afraid that not being English and being younger than them might have an influence on their willingness to talk to me. Most importantly, it was because I was worried that they would limit their desire to talk about these issues and avoid sharing their experiences with me. At first, this thought may have made me feel that I needed to establish a positive first relationship with the participants. When the interviews started, however, these fears were replaced by a feeling of trust and success.

I was concerned that the participants would share their experiences with me only in small and inadequate ways, or that there might be shortcomings in their active participation in the research. For this reason, I read widely and listened to interview techniques and ways to establish a better relationship of trust with the participants in terms of how I should pursue sensitive issues such as sexuality which people might be afraid or embarrassed to talk about. Moreover, the close relationships which I established with the participants before meeting them face-to-face were beneficial in ensuring their active participation.

Before the interviews started, I tried to predict the course of the interview by practising frequently how to collect data and brainstorming how to proceed in the face of the answers which I would get. I have seen the benefits of these preliminary activities throughout the interviews. Even so, although I practised, the knowledge which I gained during the interviews and the different experiences of the participants which I encountered challenged me from time to time. Especially in my interview with the first participant, after I had learned that she had had relationships with both men and women, I felt that I was not prepared for contact with people with different sexual orientations, and this situation was not easy for me.

Even so, I hid this feeling in the interview, and I absolutely did not want the participant, who trusted me by exhibiting a relaxed attitude as much as possible, not to shake her trust and think that I was criticizing her. Maybe the society into which I was born and raised had an impact on the fact that it forced me to talk about such issues in the first place because I realized that not speaking about such very personal and unapproved situations either in my work life or in my social circle had not prepared me for this situation. However, as a researcher, I admitted to myself that these and similar situations can happen frequently and that I should always be prepared.

As a matter of fact, in the middle of the data collection and towards the end, I heard similar stories from other participants. This time, I did not experience the feeling that I had had the first time and I was able to conduct more professional and effective interviews. This can actually be described as one of the most important indicators that I have developed as a researcher through the research for this thesis.

Although I tried to follow my interview guide, in fact, when the interviews had been conducted, I saw from the transcripts that as well as complying with the interview

schedule, I had made the participants share their opinions with me by asking them further questions about the topics which were important to them and which they wanted to share their experiences about with me. This also shows that I allowed more participants to think and speak freely. While doing this, I included the questions in the interview guide in our conversations and thus I ensured that the focus was on the answers which I wanted to receive.

As I mentioned in the previous chapters, while I was creating the interview guide, I planned to start to talk about the participants' general menopause experiences and I stated that the participants would provide more detailed and accurate information with me on more specific topics. This was helpful during the interviews, and as the conversations progressed, I realized that the participants wanted to talk more and share their experiences with me. On the other hand, sometimes some participants wanted to talk directly about the way that their sexual lives had changed after the menopause, so I respected the decision of these participants and directed the interview questions in the way that they wanted. I included the questions which I wanted to ask and some topics in the interview guide at appropriate times in the interview. In one Skype meeting, a participant stopped talking from time to time due to the fact that she had a son at home and she continued to talk while checking her surroundings. This situation might have caused the woman to restrict what she was saying. In that case, I gave her additional time and asked questions to return to the topic which she wanted to talk about later.

I tried to be as open and friendly as possible during the interviews. I had long conversations with the women before and after all the interviews. This greatly contributed to making the interviews much more open and positive. So by talking about myself from time to time to the participants, I tried to prevent them from feeling that they were in a one-sided dialogue. This technique pleased them and I think that having knowledge about me also improved our mutual communication and enabled me to gather clearer and more accurate information from them.

I had an eight-month-old baby while I was conducting the interviews and I shared this information with the participants. All the participants could feel as close as possible to me even though they were older than me, and some of them had had children and so shared their experiences with me. This led to a good bond between us. In addition,

when I told them where I was from, I had the opportunity to talk to them about my country and the places which some of them had visited in my country. Furthermore, some participants told me that I was the same age as their own child and thanked me many times for carrying out such a study; this made me very happy too. It contributed to the creation of a comfortable atmosphere between me and the participants. In addition, as I mentioned in the Methods chapter, a more comfortable environment was created because of the food, drink and flowers which I offered to them.

6.5.3 Reflexivity, data analysis and writing up

While doing the data analysis and during the writing up period, I went through a lot of thinking about how to understand and interpret the experiences which the participants had told me in the most original way because my aim in this thesis was to reveal their voices by asking questions during the interviews, taking notes during and after the interviews, asking my advisors and researching, I gave importance to interpreting them correctly and making sure that every word was understood correctly right from the start. For example, I tried to understand what exactly they meant by asking some of them what they meant by the words they used. One expression which confused me was 'mutton dressed as lamb', which I found refers to an older woman dressing as if she is a younger woman.

While listening to the experiences of women during the menopause, especially with their partners or husbands, and seeing how difficult a time women actually go through, I realized during the analysis of the data that it was emotionally challenging for me both during the interviews and throughout the analysis. I realised that I was actually embodying the women's problems as if they were my own. Especially as I read the transcripts over and over again, I realized that the feelings which I had had during the interviews had deepened in me. As a young woman myself, I realized that I was embodying what every woman said by thinking about the possibility that I could experience these things in the future, and that I understood and analysed what the women said with a sense of empathy.

The relationship between the researched and the researchers has been an issue of frequent concern in the methodology literature. The power of the researcher is mentioned in the literature (Råheim et al., 2016). I thought about how the power which

I might have by starting from here would be effective. This allowed me to see that the construction of knowledge is a combination of both the participants' comments and how I interpret their explanations.

As an international researcher, I was cautious in the analysis process, always considering the possibility of misinterpreting the women's narratives. In order to eliminate this potential risk, I spent a long time on the transcription process, as I explained in the Methods chapter. In addition, I wrote a reflection diary for each participant. In these diaries, I took notes recording every detail and feeling about the meeting. By looking at these notes during the analysis process, I ensured that my interpretations were accurate. My careful progress in the analysis process actually meant that I adhered to the interpretations and words of the participants. On the one hand, I think that as an advantage of my being an international researcher, the participants made a great effort to explain their experience with more explanation and detail, and this contributed greatly to the building of knowledge. While listening and analysing the experiences of women of different ethnicities and cultures, there were times when I actually thought that their experiences were similar to those in the place where I was born and raised at some points, although personal differences made the impact different.

6.6 Strengths and limitations

This thesis offers a rich and rare perspective on the changes and experiences in sexuality of women who are going through the menopause. It provides in-depth data at a level that cannot be obtained with quantitative studies, as discussed above. Even so, there are some limitations in this thesis as there are in every study.

For this thesis, IPA, which is a qualitative methodology, was used. Small sample sizes are recommended for the IPA methodology. For this reason, the sample was deliberately kept small, which means that the possibility of generalizing the obtained findings is limited. Even so, fourteen participants were interviewed, which is more than are recommended for IPA.

The women voluntarily participated in this study, which means that they may have been more open to talking about sensitive issue than other women in talking about their sexuality and the more private experiences of the menopause and their

relationship. In addition to this possibility, as a result of the preliminary information presented to potential participants in line with the aim and objectives of the thesis, some women might not have participated in the study due to the sensitive and private nature of the subject. This could have caused the risk of sample bias. Also, some of the participants became aware of this thesis through the Menopause Cafe and it might be the case that women who follow the menopause cafe have more knowledge about the menopause and are more likely to be prepared to talk about it. This could have contributed to selection bias. However, the variety of the sample and the fact that the majority of the participants were aware of this thesis outside the menopause cafe might have mitigated this possible source of bias.

Although participants from different cities in the UK were included in this thesis, the study was limited to a particular geographical location. The transferability of the findings to women in different ethnicities and populations of different races is therefore low. Although the findings of this thesis mean that they cannot be representative of the general female population, the sample of participants varied in terms of class, race, relationship status and sexuality. However, this is not seen as an important limitation as the purpose of this study was not to generalize the findings to a wider female population but was purposely focused on individual experiences.

Although I had a good relationship with the participants, my being an international researcher may have slightly affected their answers and therefore the findings of the thesis. Since I thought about this possibility in advance, I tried to establish close and intimate relations with them before and during the interviews as much as possible, and I believe that I was successful in this in all of the interviews. It has been recommended in the literature that future research should explore the sexual experiences of women in the menopause, excluding a sample of women who applied to any place for medical help (Yang et al., 2016). This thesis contributes to the literature as it focuses on the sexual changes experienced in the menopause and on women's relationships and how they found solutions.

CHAPTER 7: IMPLICATIONS, RECOMMENDATIONS and CONCLUSIONS

In this chapter, I shall consider the implications of the findings presented in this thesis in several areas. The first section was developed to raise awareness about the support of menopausal women by both health service providers and formal health policies. Secondly, it is aimed to raise awareness about the problems experienced by women going through the menopause and basically what they need in terms of information, education, training and support. Thirdly, suggestions are made on points which are thought to be useful for future research and ideas on the inclusion of various examples. Finally, I shall draw attention to the recommendations of the participants by presenting a summary of the recommendations made by the participants themselves.

7.1 Implications and recommendations for practice and policy

As indicated in the Findings and Discussion chapters of this thesis, the participants agreed that women going through the menopause should be supported both by health service providers and by formal health policies.

The findings have shown that most of the participants thought that they were not adequately supported by health service providers. Furthermore, the findings show that they had difficulty in getting an opportunity to talk about their sexual problems with healthcare professionals or that they could not talk about these issues with GPs because they were not asked about such issues. In addition, the participants stated that only the physical effects of the menopause or HRT were asked about by their GPs. Based on these findings, it would be beneficial for all health service providers to have conversations with women about not only nurses but also menopause symptoms (both physical and psychological) encountered in other occupational groups, sexual changes, their effects on close relationships and ways of solving these problems. Healthcare professionals should be aware of the sexual problems and sexual changes which women experience during the menopause.

For this, an education curriculum which covers not only the biomedical aspect of the menopause but also other aspects, especially its reflection on sexuality and relationships, should be provided for health professionals, especially in nursing and

medicine, as well as undergraduate education. Missing information should be provided to graduates working in the field through in-service training. In addition, it is important to keep the knowledge of those who do this job professionally fresh by updating the training at regular intervals. In the context of this training, different women's scenarios can be created from time to time, and this can ensure that ideas about when the perspective of health professionals should be put into practice. Furthermore, on 18 October, which is the annual Menopause Day across the world, interactive programmes can be organized to bring together health professionals and women. In this way, it can be possible for women to meet with health professionals and discuss the issues which they want to share with them. This can benefit health professionals by letting them listen to the experiences of more menopausal women and to acquire different perspectives.

It is important to encourage women to ask questions and to talk, especially about sexual matters. In order to deal with sexual changes, women should be supported both pharmacologically and in behaviour and attitude and health professionals should be open and encouraging to establish a dialogue with them (Yang et al., 2016). This is important because when the doctor (or health service provider) does not ask and the patient does not tell, it might not be possible to improve sexual health and decrease the existing problems, especially in menopausal and older women. Moreover, husbands or partners of women can be included in patient and GP consultations so that men have the necessary information to support the woman as stated in the Findings chapter. For instance, health professionals can contribute to men's knowledge about the menopause by giving them brochures or materials describing the menopause and its symptoms. Group meetings for men can be arranged at which men can express themselves by sharing their own experiences and can understand the experiences and problems of women about the menopause. This can contribute to a better relationship between couples. In addition, it can be difficult for men to talk about sexuality, so resources which can be easily accessed such as websites and short films for men with correct and useful information can be provided. This will contribute to men's understanding of the menopause and as a result have positive reflections on their relationships with women.

It is important to educate healthcare professionals about sexuality if we want to meet the sexual health needs of women and benefit them during the menopause (Hinchliff & Gott, 2011). Therefore, it should be ensured that all healthcare providers, especially in terms of nursing and medicine, have menopause knowledge in their basic education and subsequent in-service training, and that the effects of the menopause are known in all aspects, not just physical.

For example, some participants stated that they could not get enough information about the menopause from their GPs. Their main complaint was about the lack of information about HRT. As stated in the NICE guidelines (2015) and understood from the findings of this thesis, it is necessary to provide information about the benefits and risks of HRT and to help women to make conscious choices. The individual risks and benefits of HRT for each woman should be considered and clinicians and patients should decide together on these risks and benefits (Kohn et al., 2019).

Moreover, the weight problem was not only a health problem, but also caused anxiety in the woman and her partner about not being liked or desired in close relationships, and this was a problem in the relationship. In addition, women's worries about being judged and the social problems which women suffered from their external appearance had also become an important psychological problem of the menopause. For these reasons, it has become important for healthcare professionals to support women who want to lose weight during the menopause both physically and mentally. Health policy-makers should put these problems on the agenda and offer opportunities for healthcare professionals to provide appropriate services. Successful maintenance of weight loss is possible with lifestyle changes (Davis et al., 2012), so it is important to support women's lifestyle based on healthy nutrition and exercise.

7.2 Implications and recommendations for information, training, education and support for menopausal women

Throughout this thesis, I have provided evidence of the problems which women in the menopause experience and what they basically need and the issues which should be supported.

First, the findings have shown that women's information resources about the menopause are insufficient. This highlights the need to support women in many

different ways and fields. The participants suggested that this can be provided through television, radio, the internet, magazines and social media which are popular among women; the participants reported that they got information about the menopause from these sources. For this, programmes can be made and shown on popular television channels. Likewise, considering the widespread use of social media in recent years, it would be beneficial to support women in these areas as well. Some participants had heard about the topic of this thesis through social media such as Facebook. This shows the importance of these communication channels in providing information to women.

It is important to talk about the issues which women are embarrassed or ashamed to talk about, especially by including the effects of the menopause on sexuality and close relationships in the content of television programmes. In this way, women will see that there is nothing to be ashamed of in talking about these issues. At the same time, by including men in these television programmes and conversations, the thoughts of both sides can be expressed on the relationship between men and women. In this way, women who have the chance to watch these programmes at home with their husbands or partners might have the courage to talk to them and solve their existing problems. Based on the opinion of women that men have insufficient knowledge about the menopause, it is very important for men to understand the menopause in terms of what it means for women. If we think that men who know about the menopause and thus understand women can be more supportive and understanding to women and that this situation directly reflects on their relationships, we shall see the importance of this issue. For instance, Parish et al. (2019) found that men's awareness of their partner's menopausal transition and men's attitudes can influence their partner's menopausal symptom management. When we look at the findings of this thesis, it is clear that men should be aware of the menopause when it is taken into consideration that the participants' ability to cope with menopause symptoms according to the support which they receive from men is easier. Men should be informed about menopausal symptoms, treatment methods and how to support women.

The findings also showed that there were participants who felt they were experiencing social isolation, so activities should be organized to help women to socialize during the menopause. Like the events which the Menopause Cafe has provided, this can

bring many women together and show them that they are not alone and that they can share their experiences with each other. For this, the number and accessibility of groups such as the Menopause Cafe where women can gather and share their experiences could be increased. For example, these and similar organizations can be made more available and more accessible in different parts of the world, in the UK, Europe and different countries.

In addition, if women are in contact with each other or putting their questions to the professionals participating in these events and getting answers from the right sources, it will probably help them to solve their problems. These events enable women to see that they are not alone in their problems. In this way, progress can be made in searching for and finding solutions for issues which have been hitherto left unresolved. I saw this first hand at the Menopause Cafe activity which I attended; women shared their experiences with each other and exchanged information by talking to each other about their own solution, It might therefore be beneficial to make such events accessible to women from every segment of society. In particular, activities which can be reached by women from different education levels, ethnic groups and socio-economic levels could be organized to enable women to share knowledge and experience among themselves. If women's husbands and partners are allowed to attend these existing cafes, it can strengthen group interaction and have positive reflections on the relationship between men and women during the menopause.

It is thought that with the evidence presented throughout the thesis, there can be beneficial activities with a range of supports to be given to women. First, since the physical well-being of a woman positively affects her while she is struggling with sexual changes, special sports programs should be developed for women undergoing the menopause in order to build their physical strength through exercise. Activities and training on maintaining a healthy diet can be organized in order to contribute to the improvement of the quality of life and health of women during the menopause.

The findings showed that women with low sexual desire are undecided and lack knowledge about using medication and seeking professional help. This indicates the importance of providing adequate information and services to women regarding sexual changes, especially the lack of sexual desire experienced during the menopause. In addition, since the problem of lubrication is common during the menopause, it is

important to support women to cope with this problem because a painful sexual relationship can cause women to become more distant from sexuality with the decrease in sexual desire. This will affect both the woman's sexual life and her relationship with her partner.

It has been seen in the findings that the life of menopausal women should be supported in many ways. For this reason, action taken on the following issues may be beneficial for women. First, it is important for children (daughter and sons who are old enough to understand menopause) whose mothers enter the menopause to have knowledge about the menopause. It was seen in the analysis that children had difficulty understanding their mother's menopausal symptoms and this might lead to the relationship between mother and child in the family being negatively affected. When we consider it as an holistic health service, it is important to inform children about the menopause in order to ensure that the relationships between women and their children during the menopause are less damaged. In addition, if society can talk about the menopause more openly, our children can learn more about it and be more understanding towards their mothers.

As seen in the findings, the experiences of working women during the menopause affected them in their work lives. Sometimes this caused serious problems until the woman had to leave her job. Some women, however, had to continue their work despite all the hard times they have been through. Therefore, women undergoing the menopause should be supported by their colleagues, managers and healthcare providers in order to be able to continue working despite the decrease in their ability to work due to menopausal symptoms.

7.3 Future research priorities and recommendations

The findings presented in this thesis have clarified outstanding questions in this area, points which need to be answered by further research, and various points for which it would be useful to gain further insight. Recommendations for future research along with current priorities are therefore highlighted below.

In this thesis, findings have been presented in terms of understanding women's menopause experiences, how their close relationships and sexuality are affected, and how they struggle with these problems and more information about the menopause.

In the findings obtained from the participants, it was seen that it is important to know how men are affected by the menopause and to carry out qualitative studies in order to understand both sides and to have knowledge on which subjects women and men should be supported. These future studies could involve only men, or there could be studies involving both male and female couples together. In previous studies in which couples were involved, the thoughts of both sides on the same issues and problems arise. I think that it is important to meet with women and men both separately and together because there may be situations in which women cannot talk comfortably in front of their partners, and in the same way, men might not be able to express themselves easily in front of women. With data obtained in this way, a comparative analysis can be presented from two different perspectives. It is also important to conduct studies in society not only with heterosexual couples but also with same-sex couples to understand all kinds of menopausal impacts.

The findings showed that men's sexual problems and health problems affect menopausal women in terms of sexuality and their psychological and physical aspects. Based on this, researchers who work with men in the future can include women's views and experiences of how the problems which men experience can affect women's lives both in terms of sexuality and their psychological and physical aspects. In addition, in this thesis, the experiences of women who have experienced natural menopause were shared. In future studies, greater diversity in the sample groups could be achieved. In addition, the boundaries of existing knowledge can be expanded by the inclusion of women of different ethnic origins and cultures.

From the statements of the participants, it was seen that the menopause affects not only close relationships, but also family members, and women are also affected by the attitudes of family members. For this reason, future studies can be conducted involving the close circles of women in the menopause, especially male children. In this way, attention can be drawn to the fact that the effect of the menopause is not limited to the woman and her partner, and thus the knowledge in the literature can be extended. The information gained can benefit supporting women and the services offered.

It is important to investigate the reflections of many menopausal symptoms on a woman's sexual life and close relationship in future studies. In the results of this thesis, especially when looking at the literature, it is seen that there are women who have

sexual reluctance due to sleep problems and related fatigue. It has been seen that the sleep problem negatively affects the relationship between the woman and her partner. Based on this result, there is a need for more research on the effect of women's sleep problems on their relationships.

In the literature, there are results which show that sexual changes are mostly due to loss of sexual desire or vaginal discomfort. However, the findings presented in this thesis show that psychological factors such as body image and stress, which are related to weight gain, have a significant effect on women's sexual lives during the menopause. More studies should therefore be done to investigate the causes of sexual changes during the menopause and what affects women.

The findings of this thesis showed that the participants preferred various alternative medications and herbal remedies for menopausal symptoms. However, there is a need for more scientific data from studies on their effectiveness and to inform women about using the most appropriate and beneficial alternative medication and herbal remedies. In particular, the evidence regarding the effect of Maca powder on menopausal symptoms, which women in the menopause use as a herbal remedy, is uncertain given the few previous studies on this subject. More studies are therefore needed on this subject (Taylor, 2015).

7.4 Participants' advice to other women in their situation

As the final question of the thesis, the participants were asked for their advice: 'If you were to give advice to other women in your situation, what would it be?' I think that their advice is valuable and I have summarised it in the following paragraphs

The main points of the advice given by the participants were actually about the subjects which they could not do or which they thought were successful. Most of the participants mentioned the importance of talking about the menopause and sharing their experiences with others such as friends, family members, partner and GP. They believed it would be helpful to get advice from the people with whom they talked. For example, Fiona said that it is important to talk to mothers and aunts about what kind of menopause they had experienced before women go through the menopause themselves. Kath stated that it would be helpful for women to talk with friends about

what they went through during menopause, how they felt, and what symptoms they had experienced.

Some participants especially stated that it is important for women to talk to their partners about the menopause so that their partners can understand them better and recommended what they might do. In particular, Gina also talked about the importance of talking about the menopause socially, and she thought that the more people talked about it, the better her partner would understand it and perhaps treat her differently:

*- **Gina:** ... But the more people talk about it the more understanding there is; maybe if my partner had a better understanding, you know, he wouldn't behave the way he did ...*

In addition, some participants stated that it is necessary to share their dissatisfaction with their sex life with their partners, but some of them said that they could not do this because they thought it was not possible to talk with their partners.

On the other hand, some participants, especially those who had continued their work-life, recommended that it is important for women to tell their colleagues and managers that they have difficulties with menopausal symptoms which directly affect their working life, such as brain fog, bad mood, memory problems, sleep problems and hot flushes, for them to be able to continue to work during the menopause:

*- **Kath:** Definitely I think if you talk to people at work ... because that's a hard part for ladies that go through, and try to maintain your work life, you know if you're at a set level, that all of a sudden because you've got brain fog or you're not sleeping, you're not working at the same level, [so] explain to them why.*

Mary also drew attention to the same subject by emphasizing the following point in particular:

*- **Mary:** ... That's one thing I've learnt: if you don't tell people how you are feeling, they're not mind readers, they're not going to know, you know, as I said to you before ...*

Among the most common advice given by the participants was that women should have knowledge about the menopause. This included general menopause knowledge as well as treatment methods and especially HRT. For example, Belinda advised

starting reading, thinking and getting information beforehand and not waiting until the symptoms get worse. In addition, Camila emphasized that women need to do research on the menopause starting in their 20s and 30s in order have the knowledge, and thus begin to prepare themselves both physically and mentally.

They often cited the importance of television and radio programmes as ways to gain knowledge, such as BBC Breakfast and Mariella Frostrup's television programme. They suggested that it would be beneficial for women to watch and listen to these programmes. Some participants stated that it would be beneficial to talk to the GP and ask their GP or any specialist about any questions they have.

Most of the women using HRT had insufficient knowledge before starting HRT, so they advised women to learn about the risks and advantages of HRT by doing as much research as possible. They also recommended that applying to a specialist in this regard is of great importance in combating menopausal symptoms. There were participants who advised them not to be afraid of HRT:

*- **Camila:** There was a lot of controversy ... in the media for many years and it was really made out to be 'Oh no, no you can't possibly take that because HRT increases your risk of breast cancer'. But really when you actually do the research and you actually look into it, the risks are very limited, not very high ...*

Apart from these comments, the participants gave advice to women based on their experiences in promoting general health. They talked about the importance of healthy living, doing sports and diet. Dawn advised that being busy with something like sports, reading, swimming, walking and continuing her business life could prevent her from constantly listening to herself and thinking more about the menopause.

There were participants who made recommendations on what attitude women should have towards the menopause. For example, Angela stated that it was necessary to accept the changes which occurred: she actually saw the menopause as reverse puberty. She stated that instead of fighting it with drugs, it is necessary to resort to natural ways. Most importantly, "Not to give in to the menopause but to accept it and not let it beat you". Isabel also emphasized that the menopause should be taken seriously:

- Isabel: ... I think, take it seriously. You know it's part of life. And just, you've just got to roll with it. And don't get yourself anxious about it or worried about it, how others are going to see you or whatever ...

There were participants who gave advice on not being affected by the perception of the menopause created by society. Helen, for example, advised that you should not let the feeling of being unattractive by society just because you are old affect you:

- Helen: What would I say? I would say you're gorgeous just as you are. Well, you know, whether you're – you're lovely regardless of what age you are or what. And to sort of try not to let that feeling of not being attractive affect you just because you're older. I think older women are very beautiful, but society doesn't.

Finally, all of the participants recommended that more studies should be done on the effects of the menopause, especially on the close relationship.

7.5 Thesis conclusion

The primary aim of this thesis was to explore post-menopausal women's experiences of the menopause, the perceived impact which the menopause can have on their interpersonal relationships and intimacy, and the coping methods which they used. In addition to the aim of the thesis, specific objectives were developed and interview questions were created in line with these.

The impact of the menopause on the lives of post-menopausal women is striking. The findings showed the difficulties experienced by the participants as a result of the many emotional and physical changes in their sexual lives caused by the menopause. It can be said that changes in the level of sexual desire were the most prominent among them.

Despite the sexual changes experienced, most of the participants were reluctant to use medication, specifically HRT, contrary to the notion that sexual changes are a result of hormonal changes, which are seen as the main reason. Most of the participants preferred natural methods and alternative medicines more than HRT for combating the physical and psychological symptoms of the menopause. Although

HRT has never been recommended for sexual changes, some participants had used HRT for their menopausal symptoms.

All of the participants believed that the menopause had an effect on their relationship. Most of the participants' relationships were greatly affected by the sexual changes experienced during the menopause and were the main effect of menopausal symptoms. They were worried about their relationships, were afraid of losing their husband/partner and felt guilty when they could not satisfy him sexually. These findings show the importance of the menopause in the emotional and relational life of women.

The use of IPA enabled an in-depth investigation of the participants' lived experiences. The sample selection, the methodology used, IPA, and the information obtained as a result of detailed analyses contribute to the literature both theoretically and methodologically. Among these contributions, an important result is the suggestion of a different perspective for health services in regard to the advice and support to be given to post-menopausal women. There is an additional important result in terms of the light which the findings have shed on future research directions.

Due to the lack of qualitative research in the literature, this thesis also contributes to understanding the experiences of post-menopausal women from many different perspectives, mainly interpersonal relationships, intimacy, sexual changes and coping methods. Health professionals should be aware of the changes which post-menopausal women go through and should show women that they are willing to discuss these issues with them in order to help them cope with the changes which they are experiencing

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APPENDICES

Appendix 2.1: The two literature review search strategies

From January 2005 to May 2018

Search terms	CINAHL	Pubmed	PsyhINfo	Applied Social Science Index Abstract (ASSIA)	Web of science Core collection	TOTAL
Menopause AND relationship AND sex	64	436	61	217	320	1098
Postmenopausal women AND sex AND relationship*	52	369	44	150	931	1546
Postmenopausal women AND intima*	56	187	13	48	572	876
Postmenopausal women AND intima* AND relationship*	12	20	5	42	139	218
Total	184	1012	123	457	1962	3281

From June 2018 to September 2020

Search terms	CINAHL	Pubmed	PsychInfo	Applied Social Science Index Abstract (ASSIA)	Web of science Core collection	TOTAL
Menopause AND relationship AND sex	28	128	7	35	96	294
Postmenopausal women AND sex AND relationship*	25	80	2	18	125	250
Postmenopausal women AND intima*	19	51	0	3	80	153
Postmenopausal women AND intima* AND relationship*	4	16	0	3	21	44
Total	76	275	9	59	322	741

Appendix 2.2: Summary of the purpose of each qualitative study

Published from January 2005 to May 2018

ID No.	Authors/Years	Country	Purpose
1	Bellamy, Gott & Hinchliff (2013)	UK	To explore women's understandings of sexual problems
2	Caçapava Rodolpho et al. (2016)	Brazil	To explore men's perceptions, experiences and attitudes toward their wives experiencing natural menopause
3	Faccio et al. (2017)	Italy	To investigate how professionals, women diagnosed with hypoactive sexual desire disorder and ordinary people, both men and women, signify this phenomenon in the Italian context
4	Feltrin & Velho (2014)	Brazil	To understand the experience of sexuality after menopause among a group of women, through their life experiences, considering the construction of meanings attributed to this phase by doctors and patients in the gynaecologist's office environment.
5	Ghazanfarpour, Khadivzade & Roudsari (2018)	Iran	To explore the perceptions and experiences of GPs and midwives during their discussions of sexual issues with menopausal women
6	Hinchliff & Gott (2008)	UK	To explore the importance of sexual activity to women aged 50 and over and to look at the ways in which they talk about sex.
7	Hinchliff, Gott & Ingleton (2010)	UK	To examine the changes in sexual activity which women can experience at menopause and the impact on the psychological well-being
8	Hinchliff, Gott & Wylie (2012)	UK	To examine the ways in which heterosexual women renegotiated their sexual relationships in the context of close interpersonal relationships

9	Hyde et al. (2011)	Republic of Ireland	To analyse the accounts of menopausal women about their heterosexual experiences and to consider these data in relation to existing theoretical perspectives on sexuality
10	Ling, Wong & Ho (2008)	China	To explore the concerns and issues specific to sexual behaviours and interests among post-menopausal women; and to examine factors which might affect their willingness to seek medical attention for sexual issues
11	Moghasemi et al. (2018)	Iran	To investigate Iranian women's attitudes towards and experiences of sexual life changes in midlife
12	Nosek, Kennedy & Gudmundsdottir (2012)	US	To examine the experiences of distress in women during the menopause transition
13	Ussher, Perz & Parton (2015)	Australia	To critically examine women's experiences of sexuality during and after the menopausal transition
14	Wood, Mansfield & Koch (2007)	US	To understand the meaning and experience of post-menopausal women's sexual desire from a feminist perspective
15	Yang et al. (2016)	Taiwan	To examine Taiwanese women's perspectives on the way menopause affected their sexual behaviour to gain an in-depth understanding of their experiences during this transition

Published from June 2018 to September 2020

ID No.	Authors/Years	Country	Purpose
1	(Thomas et al., 2020)	US	To explore factors which contribute to low libido among sexually active women 60 and older using a qualitative approach
2	(Vidayanti & Retnaningsih, 2020)	Indonesia	To explore the sexual experience of post-menopausal women in a rural area in Yogyakarta

Appendix 2.3: Summary of geographical settings, research methods, methods of collecting data and participants for each qualitative study

Published from January 2005 to May 2018

ID No	Author s/Years	Design	Country	Setting	Sampling	Sample or Participants	Data collection	Data Analysis
1	Bellamy , Gott, & Hinchliff (2013)	Qualitative	UK	The general public and a psychosexual clinic	No information	23 women aged 23–72 years	Individual in-depth, semi-structured interviews	Template analysis
2	Caçapa va Rodolp ho et al. (2016)	Qualitative	Brazil	A primary health unit (PHU), a healthcare facility of the Brazilian public health system, located in the central area of São Paulo City	No information	20 men	In-depth, face-to-face interviews or telephone interviews	No information
3	Faccio et al. (2017)	Qualitative	Italy	A private practice in Padua, in northern Italy	No information	146 participants (48 experts, 48 women with hypoactive sexual desire disorder aged 41–60, mean age 50.4; 50	Face-to-face interview	Thematic analysis

						ordinary people, 25 female, aged 45–60, mean age 53.4; and 25 male, aged 46–55, mean age 50.5 who did not report having sexual problems		
4	Feltrin & Velho (2014)	Qualitative	Brazil	Menopause Outpatient at a Women's Healthcare Centre in a Brazilian university hospital	No information	99 post-menopausal women patients, average age 57 years old.	Interviews	Ethnographic material
5	Ghazanfarpour, Khadivzade & Roudsari (2018)	Qualitative	Iran		Purposive sampling	13 midwives and 12 general practitioners	Semi-structured interviews	Qualitative content analysis
6	Hinchliff & Gott (2008)	Qualitative	UK	Sheffield	Letters of invitation	19 women aged 50 and older, mean age 61.9	In-depth interviews	A Foucauldian discourse analysis
7	Hinchliff, Gott &	Qualitative	UK	Two general practices in South Yorkshire	Purposive	12 post-menopausal women,	Interviews	A Foucauldian

	Ingleton (2010)					aged 48–60, mean age 54.2		discourse analysis
8	Hinchliff, Gott & Wylie (2012)	Qualitative	UK	A psychosexual clinic in northern England	Purposive sampling	23 women, 23–58 years, mean age 39.6	In-depth interviews	A material-discursive framework
9	Hyde et al. (2011)	Qualitative	Republic of Ireland	Women's Health Council; a traveller organisation	Purposive	25 post-menopausal women 42–63 years of age, average age, 54.2	Individual interviews; one focus group	Thematic networks
10	Ling, Wong & Ho (2008)	Qualitative	China	The Centre of Research and Promotion of Women's Health at the School of Public Health of the Chinese University of Hong Kong	Invited by telephone	22 early post-menopausal women aged 50–64 years	Semi-structured focus group discussions	Grounded Theory
11	Moghasemi et al. (2018)	Qualitative	Iran	Urban health centres	Purposeful sampling	17 women aged 40–65 years; 8 postmenopausal 7 early menopausal 2 late menopausal	Face-to-face, semi-structured and in-depth interviews	Graneheim and Lundman's approach. MAXQDA 10
12	Nosek, Kennedy & Gudmu	Qualitative	US	Two cities in California,	No information	15 menopausal and post-menopausal	In-person interviews	A narrative analysis methodology

	ndsdottir (2012)					women aged 40-60 years		
13	Ussher, Perz & Parton (2015)	Qualitative	Australia	<p>Study 1: Women's health centres and GPs' surgeries</p> <p>Study 2: Cancer support groups and cancer newsletters, media stories in local press, hospital clinics and local cancer consumer websites and telephone help-lines.</p>	No information	<p>Study 1: 21 women aged 41-56 years, average age 49</p> <p>Study 2: 39 women aged 20-71, average age 49</p>	Semi-structured, in-depth interviews face-to-face or by telephone.	Thematic decomposition
14	Wood, Mansfield & Koch (2007)	Qualitative	US	TREMIN Research Program on Women's Health	Purposeful or criterion-based sampling	22 post-menopausal women aged 58 to 65 years; average age 62 years	Audio-taped, semi-structured telephone interviews	Grounded theory with three types of coding: open coding, axial coding and selective coding,
15	Yang et al. (2016)	Qualitative	Taiwan	An urban medical centre	No information	18 women (peri- or post-menopausal) mean age 52.15	Face-to-face interviews using open-ended questions	Content analysis

Published from June 2018 to September 2020

ID No	Author s/Years	Design	Country	Setting	Sampling	Sample or Participants	Data collection	Data Analysis
1	(Thomas et al., 2020)	Qualitative	US	Women recruited from the general public of Pittsburgh using social media, flyers placed in senior centers and doctors' offices, the University of Pittsburgh Clinical and Translational Research Institute research registry, and the University of Pittsburgh Claude D. Pepper Older Americans Independence Center research registry	No information	15 individual interviews and 3 focus groups (total n=36) with sexually active women aged 60 and older who screened positive for low libido using a validated instrument	Individual in-depth, face-to-face interviews and focus groups	Coding used a fine-grained, phenomenological approach. Codes were then examined using thematic analysis to draw out key themes.
2	(Vidayanti & Retnani, 2020)	A descriptive qualitative study	Indonesia	Recruited from the working area of the Public Health Centre in Sleman Regency, Yogyakarta	Purposive	Twelve postmenopausal women aged 50-60 years who had no longer menstruated for 12 months	Individual face to face, semi-structured and in-depth interviews	Qualitative research with a phenomenological approach

Appendix 2.4: Summary of the purpose of each quantitative study

Published from January 2005 to May 2018

ID No.	Authors/Years	Country	Purpose
1	Bello & Daramola, (2016)	Nigeria	To determine the level of awareness of and perceptions about the menopause and sex in peri-menopausal women attending a general outpatient clinic
2	Birnbaum, Cohen & Wertheimer (2007)	Israel	Two studies examined the contribution of ageing to various aspects of sexual functioning: - Study 1 : to examine the association between age and sexual response among 289 women; - Study 2 : to examine the association between menopausal status (pre-, peri- and post-menopausal) and partnered women's sexual functioning and related effects and cognition
3	Chua et al. (2017)	Indonesia, Malaysia, Singapore, Taiwan and Thailand	To examine women's experiences with GSM and their interactions with healthcare professionals
4	Dasgupta & Ray (2017)	India	To explore the relationship between menopausal status and attitudes toward menopause and ageing
5	Domoney et al. (2013)	UK	To understand the physical and emotional impact of post-menopausal vaginal discomfort on relationships between women and their male partners
6	Guidozzi et al. (2017)	South Africa	To investigate the impact of post-menopausal vaginal atrophy on women and male partners in South Africa

7	Jarecka & Bielawska-Batorowicz (2017)	Poland	To evaluate the occurrence and intensity of menopausal symptoms, taking into account the length of the women's relationship, its nature and their assessment of it
8	Kingsberg et al. (2013)	US	To characterize post-menopausal women's experience with and perception of VVA symptoms, interactions with healthcare professionals and available treatment options
9	Kingsberg (2014)	US	To assess women's attitudes toward the menopause and how it affects their personal relationships, along with their level of awareness of low sexual desire as a medical condition and treatment-seeking history
10	Minkin, Reiter & Maamari (2015)	North America and Europe	To evaluate differences and similarities in the prevalence of post-menopausal symptoms and their impact on post-menopausal women and the male partners of post-menopausal women
11	Mishra & Kuh (2006)	UK	To examine relationships between women's reports of a change in sex life and difficulties with intercourse and their experience of menopausal transition, use of hormone therapy, and hysterectomy
12	Moghassemi, Ziaei & Haidari (2011)	Iran	To determine the prevalence of sexual dysfunction in Iranian post-menopausal women and the relationship between the serum status of sex hormones and sex hormone binding globulin (SHBG)
13	Nobre & Pinto-Gouveia (2006)	Portugal	To investigate the differences in sexual beliefs presented by men and women with sexual dysfunction and their sexually functional counterparts
14	Nappi & Nijland (2008)	Six European countries (UK, France, Germany, Italy, The Netherlands, Switzerland)	To generate broad findings on women's perceptions and experience of sexuality around the menopause in six European countries
15	Nappi et al. (2013a)	Northern and	To investigate how post-menopausal vaginal atrophy ('vaginal discomfort') affects relationships between women and their partners

		Southern Europe	
16	Nappi et al. (2013b)	UK, Finland, Norway, Sweden, Denmark, Italy, France, Canada, and the US	To evaluate the impact of vaginal atrophy on the physical and emotional aspects of sexual relationships between post-menopausal women and their male partners
17	Nappi et al. (2015)	Italy, Germany, Spain and the UK	To achieve a better understanding of vulvovaginal atrophy (VVA), a chronic and progressive condition after menopause, and to investigate perceptions, experiences and needs in terms of sexual and vaginal health in a sample of European post-menopausal women
18	Nappi et al. (2016a)	Italy	To achieve a deeper understanding of the attitudes and perceptions of Italian post-menopausal women regarding VVA.
19	Nappi et al. (2016b)	Italy, Germany, Spain and the UK	To achieve a better comprehension of the variability of perceptions, experiences and needs in terms of sexual and vaginal health in post-menopausal women from four European countries
20	Peeyananjarassri et al. (2008)	Thailand	To study sexual functioning and attitudes towards sexuality in post-menopausal women
21	Taavoni et al. (2005)	Iran	To determine attitudes about the importance of sex in menopausal women and examine the relationship between HRT and sex life after menopause
22	Yücel & Eroğlu (2013)	Turkey	To identify the problems that women have in their sexual lives in the post-menopausal period and the methods which they use to cope with these problems

23	Simon et al. (2014)	North America	To determine the emotional and physical impact of vaginal atrophy on North American post-menopausal women and their male partners
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Published from June 2018 to September 2020

ID No.	Authors/Years	Country	Purpose
1	(Golzari et al., 2020)	Iran	To investigate the effect of sexual knowledge, sexual attitude and religious health on predicting the sexual function of post-menopausal women
2	(Hong et al., 2019)	South Korea	To test a hypothetical path model evaluating the influence of menopause symptoms on sexual function among middle-aged, peri-menopausal women, as well as to identify the mediating roles of body image, depression and sexual communication in this relationship
3	(Nazarpour, Simbar, Ramezani Tehrani, et al., 2018)	Iran	To examine the relationship between quality of life and sexual function among post-menopausal women
4	(Parish et al., 2019)	US	To gauge men's awareness of menopausal symptoms and understanding of the menopause and its treatment options, and to evaluate the impact of menopausal symptoms on men and determine the influence of men on their partner's menopausal symptom management

Appendix 2.5: Summary of geographical settings, research methods, methods of collecting data and participants in studies

Published from January 2005 to May 2018

ID No	Authors /Years	Design	Country	Setting	Sampling	Sample or Participants	Data collection	Data Analysis
1	Bello & Daramola (2016)	A cross-sectional, descriptive design	Nigeria	Family Medicine Department of University College Hospital		352 women aged over 40 years; mean age 46.3 ± 4.0 years	A structured closed- and open-ended questionnaire	Chi-square tests IBM SPSS Statistics 20 software.
2	Birnbaum, Cohen & Wertheimer (2007)	Quantitative, cross-sectional	Israel	Community centres in the central area of Israel.		Study 1: 289 women ranging in age from 24 to 62 years Study 2: 93 Israeli women ranging in age from 24 to 60 years	The Israeli Sexual Behavior Inventory; A Hebrew version of the Women's Sexual Working Models Scale	One-way multivariate analyses of variance (MANOVAs)

3	Chua et al. (2017)	Quantitative	Indonesia, Malaysia, Singapore, Taiwan, and Thailand			5992 women aged 45–75 years	Self-completed surveys	Descriptive statistics
4	Dasgupta & Ray (2017)	Quantitative	India		Random sampling	1,400 Bengali Hindu women aged 40–55 years	A structured questionnaire	SPSS software (version 18.0), descriptive statistics
5	Domoney et al. (2013)	Quantitative	UK			Post-menopausal women aged 55–65 years, who had experienced vaginal discomfort, and the male partners of such women: 500 women and 500 men	A structured questionnaire, and internet-based survey	
6	Guidozzi et al. (2017)	Quantitative	South Africa			200 post-menopausal women who had	A structured	

						experienced symptoms of vaginal atrophy, and 200 male partners	questionnaire	
7	Jarecka & Bielawska-Batorowicz (2017)	Quantitative	Poland			200 women aged between 45 and 68	Questionnaire	The Women's Health Questionnaire, and the Partner Relations Questionnaire
8	Kingsberg et al. (2013)	Quantitative	US			3,046 post-menopausal women with VVA symptoms	A comprehensive on-line questionnaire	
9	Kingsberg (2014)	Quantitative	US			450 pre- and post-menopausal women aged 20 to 60 years	Online survey	
10	Minkin, Reiter & Maamari (2015)	Quantitative	North America and Europe			8,200 respondents: 4,100 were post-menopausal women who had	Internet-based survey	

						experienced vaginal discomfort and 4,100 were male partners of post-menopausal women with this symptom		
11	Mishra & Kuh (2006)	Quantitative cohort study	UK		Random sample	1,525 women aged 47 to 54	Questionnaire	Statistical analysis
12	Moghassemi, Ziaei & Haidari (2011)	Quantitative cross-sectional study	Iran			149 healthy post-menopausal women aged 43–64	Female Sexual Function Index.	
13	Nobre & Pinto-Gouveia (2006)	Quantitative	Portugal	Control sample from the Universidade de Trás-os-Montes e Alto Douro; clinical sample from the sexology clinic of Coimbra's University Hospital	No information	488 participants: 160 females and 232 males without sexual problems; 47 females and 49 males with a DSM-IV diagnosis of sexual dysfunction	The International Index of Erectile Function (IIEF); The Female Sexual Function	

							Index (FSFI); Sexual Dysfunction Beliefs Questionnaire (SDBQ)	
14	Nappi & Nijland (2008)	Quantitative	Six European countries (UK, France, Germany, Italy, The Netherlands, Switzerland)			1805 post-menopausal women aged 50–60 years	Computer-assisted telephone interviewing	Spearman correlation analysis and linear regression analysis
15	Nappi et al. (2013a)	Quantitative	Northern and Southern Europe			1600 women and 1600 men from Northern Europe and 1000 women and 1000 men from Southern Europe. The post-menopausal	online questionnaire	

						women were aged 55–65 years		
16	Nappi et al. (2013b)	Quantitative	United Kingdom, Finland, Norway, Sweden, Denmark, Italy, France, Canada, and the United States			4100 females and 4,100 males	Online survey	Descriptive data
17	Nappi et al. (2015)	Quantitative	Italy, Germany, Spain and the UK			3768 post-menopausal women aged 45–75 years	Questionnaire	
18	Nappi, et al. (2016a)	Quantitative	Italy			1000 post-menopausal women	Online questionnaire	Descriptive statistics
19	Nappi et al. (2016b)	Quantitative	Italy, Germany, Spain and the UK			3768 post-menopausal aged 45-75 years	Online questionnaire	

20	Peeyan anjarassri et al. (2008)	Cross-sectional study	Thailand	Gynaecological and menopause clinic, Songklanagarind Hospital		219 healthy post-menopausal women with a uterus, aged 45-55 years.	The Female Sexual Function Index (FSFI) questionnaire	
21	Taavoni et al. (2005)	Comparative study	Iran	Private gynaecology clinics in the north of Tehran		154 women receiving HRT, 130 women not receiving HRT	Questionnaire	Descriptive and inferential statistics
22	Yücel & Eroğlu (2013)	Quantitative	Turkey	A primary health care centre in Ankara		309 women aged 45-65 years	Questionnaire	Statistical Package for Social Sciences (SPSS) 13.0 for Windows. percentages, Pearson Chi square and Fisher's Exact Test
23	Simon et al. (2014)	Quantitative	North America			1,000 post-menopausal women aged 55-65 years and 1,000 male	Online survey	

						partners of post-menopausal women aged 55-65 years		
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Published from June 2018 to September 2020

ID No	Authors/Years	Design	Country	Setting	Sampling	Sample or Participants	Data collection	Data Analysis
1	(Golzari et al., 2020)	Descriptive correlational study	Iran	Qazvin comprehensive health care centers	Convenience sampling	258 post-menopausal women, average age; 52.92±5.34 years	A demographic and sexual function questionnaire; the Female Sexual Function Index (FSFI) questionnaire	Descriptive statistics using SPSS software.

							aire; Sexual Knowledg e and Attitudes Scale (SKAS); and Spiritual Well- Being Scale (SWBS)	
2	(Hong et al., 2019)	Cross-sectional survey	South Korea	J, I and G cities in South Korea	-	250 middle-aged, perimenopausal women	Questionnaire	IBM SPSS Statistics 25.0 (IBM Corp.) and AMOS 23.0.
3	(Nazarpour, Simbar, Ramezani Tehrani, et al., 2018)	Cross-sectional study	Iran	All residents of the cities of Chalous and Noshahr, located in northern Iran.	Multistage sampling method.	405 postmenopausal women, mean age; 51.2 ± 3.5 years	Female Sexual Function Index (FSFI) questionnaire; the WHO Quality of Life-BREF	SPSS (version 18); Pearson correlation coefficient; Spearman's correlation coefficient; t-test, and multiple linear regression

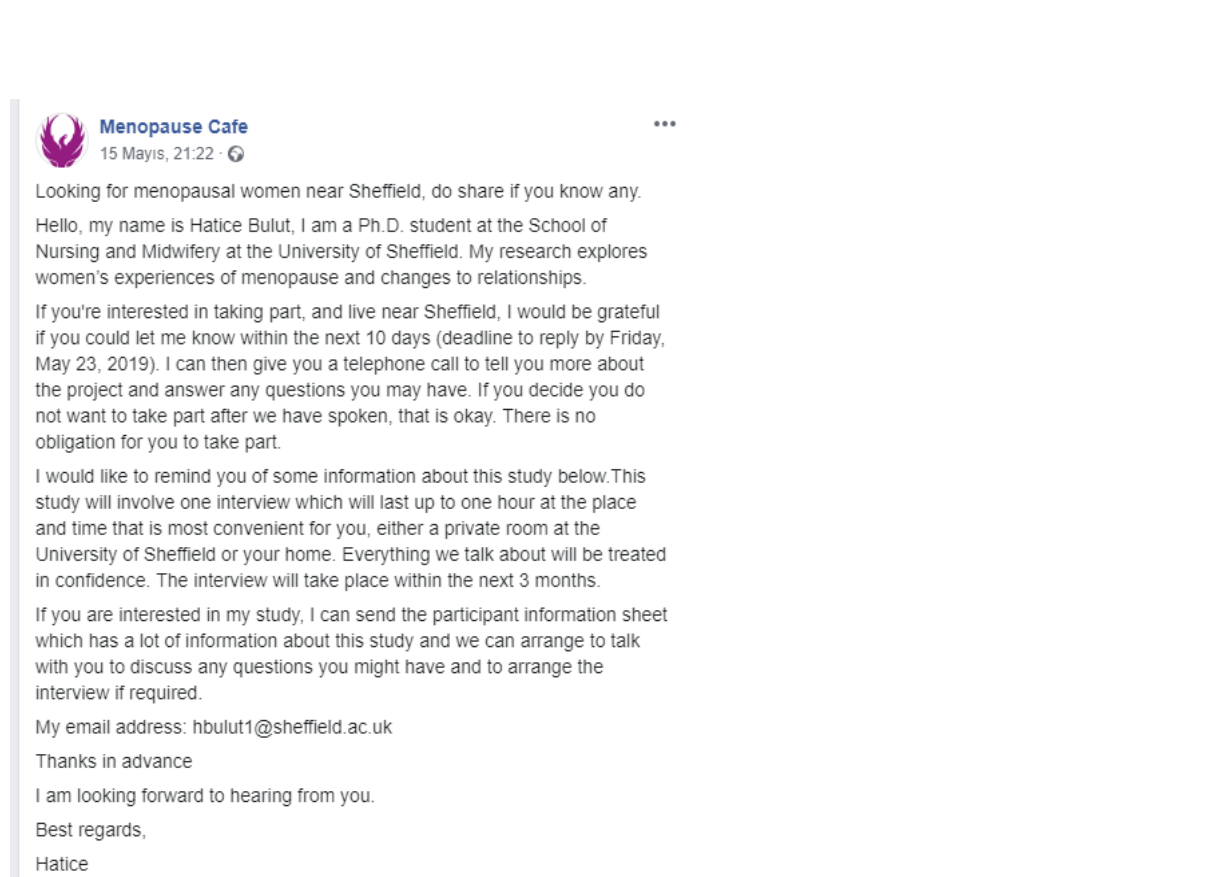
							(WHOQOL-BREF) questionnaire; and a researcher-administered questionnaire	
4	(Parish et al., 2019)	Online survey	US	Therapeutics MD (Boca Raton, FL)	Men residing in the US who were registered with an online global insight marketplace (Cint) were invited to participate in the survey and had to	Invitations were sent to 1,356 eligible men, and 450 completed the survey (33.2% response rate).	A 35-question online survey	

					double-opt in by e- mail.			
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Appendix 4.1: Consent to take part in research

- Capacity to consent will be determined throughout the recruitment period. The researcher will note that consent is obtained when:
- Women verbally give consent and sign the Consent Form
- They are not incapacitated by alcohol or other drugs
- They do not have a problem that significantly affects their cognitive capacity
- They give their consent voluntarily and without coercion

Appendix 4.2: Advertisement in the Menopause Cafe Facebook pages



Menopause Cafe
15 Mayıs, 21:22 · 🌐

Looking for menopausal women near Sheffield, do share if you know any.

Hello, my name is Hatice Bulut, I am a Ph.D. student at the School of Nursing and Midwifery at the University of Sheffield. My research explores women's experiences of menopause and changes to relationships.

If you're interested in taking part, and live near Sheffield, I would be grateful if you could let me know within the next 10 days (deadline to reply by Friday, May 23, 2019). I can then give you a telephone call to tell you more about the project and answer any questions you may have. If you decide you do not want to take part after we have spoken, that is okay. There is no obligation for you to take part.

I would like to remind you of some information about this study below. This study will involve one interview which will last up to one hour at the place and time that is most convenient for you, either a private room at the University of Sheffield or your home. Everything we talk about will be treated in confidence. The interview will take place within the next 3 months.

If you are interested in my study, I can send the participant information sheet which has a lot of information about this study and we can arrange to talk with you to discuss any questions you might have and to arrange the interview if required.


My email address: hbulut1@sheffield.ac.uk

Thanks in advance

I am looking forward to hearing from you.

Best regards,
Hatice

Advertisement in the Menopause Cafe facebook page

 **Menopause Cafe Sheffield** 21 saat ·  

RESEARCH OPPORTUNITY..... Can you help or share with someone who can.

We have been approached by a Ph.D student to see if our community can help. Please see below

Looking for menopausal women near Sheffield, do share if you know any.

Hello, my name is Hatice Bulut, I am a Ph.D. student at the School of Nursing and Midwifery at the University of Sheffield. My research explores women's experiences of menopause and changes to relationships.

If you're interested in taking part and live near Sheffield, I would be grateful if you could let me know within the next 10 days (deadline to reply by Friday, June 7, 2019). I can then give you a telephone call to tell you more about the project and answer any questions you may have. If you decide you do not want to take part after we have spoken, that is okay. There is no obligation for you to take part.

I would like to remind you of some information about this study below. This study will involve one interview which will last up to one hour at the place and time that is most convenient for you, either a private room at the University of Sheffield or your home. Everything we talk about will be treated in confidence. The interview will take place within the next 3 months.

If you are interested in my study, I can send the participant information sheet which has a lot of information about this study and we can arrange to talk with you to discuss any questions you might have and to arrange the interview if required.

My email address: hbulut1@sheffield.ac.uk

Thanks in advance

I am looking forward to hearing from you.

Best regards,

Hatice

Advertisement in the Menopause Cafe Sheffield Facebook page

Appendix 4.3: Participant Information Sheet



An Interpretative Phenomenological Analysis of postmenopausal women's experiences of menopause, impact on relationship/intimacy and coping methods

I would like to invite you to take part in a research study. Before you decide you need to understand why the research is being done and what it would involve for you. Please take time to read the following information carefully and please contact me if you have any questions or require any further information. You can find my details at the end of this information sheet. Thank you for taking the time to read this information sheet.

What is the purpose of the study?

The aim of the study is to explore women's experiences of menopause and the perceived impact menopause may have on their interpersonal relationships and intimacy. This is a 3-year doctoral study.

Why have I been asked to take part in the study?

You have been invited because you are a woman who is up to 70 years old and your last menstrual period is over 12 months ago. I would like to talk about your menopause experiences, relationship and intimacy. There will be approximately 10 other participants involved in this study who will be interviewed separately.

Do I have to take part?

You can decide if you want to participate. I will explain the study, go through this sheet with you and you may ask any questions that you may have. If you decide that you would like to participate, you will be asked to sign two Consent Forms to show that you agree to take part. I will keep one copy and you will keep the other. If you decide that you do not wish to take part, you can withdraw at any point without giving a reason.

What will happen to me if I take part? What do I have to do?

This study will involve one interview which will last between around one hour at the place and time that is most convenient for you, either a room at the University of Sheffield or your home. I will be the only other person present during the interview. We will begin your interview with some general questions and then move on to discussing menopause experiences, relationship and intimacy.

If you feel uncomfortable discussing any topic area, please let me know.

What will happen if I take part in a telephone/ Skype (or equivalent) interview?

- The interviews will be conducted at a time convenient for you.
- The researcher has a dedicated private room in the University that she will use when conducting interview.
- The interview will be recorded using applications compatible with the platform used and which will allow the download of the interview to be kept securely.
- Consent Forms will be sent to you via email before the interview(s) or post whichever suits the best. You will return the Consent Form by post (a self-addressed envelope with a stamp will be provided) and the interview will not take place until the signed form has been received. If the consent form has not been returned to me within 10 days, I will contact you by email/telephone to check if you still want to take part and if so, to ask you to return the Consent Form.
- Privacy is important during Skype (or equivalent) interviews. Therefore, the researcher will set up her webcam so that you can see that the researcher is alone in a private room and is confident that discussion is conducted in private. During Skype interviews the webcam does not need to be turned on if you prefer just to use voice.
- Only audio recording will be made, and notes will be taken to note any nonverbal cues or problems throughout the interview.

What are the possible disadvantages and risks of taking part?

Although interviews are not expected to cause trouble, talking about specific experiences may be upsetting for you. If you do not want to continue, we can stop the interview at any point and if you need to talk to someone after the interview, I will be available.

What are the possible benefits of taking part?

The interview can give you the opportunity to tell your story and strengthen your conversation about your subjective experiences by sharing your menopausal experiences. Some benefits may not be directly for you, but it is hoped that the findings from this research will contribute to the existing literature and improve the healthcare women receive at menopause.

Will my taking part in this project be kept confidential?

All the information that we collect about you during the course of the research will be kept strictly confidential and will only be accessible to members of the research team. You will not be able to be identified in any reports or publications unless you have given your explicit consent for this. If you agree to us sharing the information you provide with other researchers (e.g. by making it available in a data archive) then your personal details will not be included unless you explicitly request this'.

Will I be recorded, and how will the recorded media be used?

Our interview will be audio-recorded and after the interview I will transcribe (type out) our discussion onto a computer. When I transcribe our interview, I will use a false name and make sure that no details that could identify you are included.

The recording and computer will be kept in a locker that only I have access to and the computer will be password protected to make sure that your information will be protected. Only the researcher and her supervisory team (Dr. Sharron Hinchliff, Dr. Parveen Ali and Dr. Hilary Piercy) will have access to the anonymised recording. The recording will be destroyed one month after I have transcribed it.

My copy of your Consent Form will also be kept in the locker to ensure your confidentiality.

What will happen if I don't carry on with the study?

If you withdraw from the study, during the interview or up to one month after the interview, all your data will be destroyed. One month after the interview, withdrawal will not be possible.

What is the legal basis for processing my personal data?

According to data protection legislation, we are required to inform you that the legal basis we are applying in order to process your personal data is that 'processing is necessary for the performance of a task carried out in the public interest' (Article 6(1)(e)). Further information can be found in the University's Privacy Notice <https://www.sheffield.ac.uk/govern/data-protection/privacy/general>.'

As we will be collecting some data that is defined in the legislation as more sensitive (information about experiences of menopause, impact on relationship/intimacy and coping methods), we also need to let you know that we are applying the following condition in law: that the use of your data is 'necessary for scientific or historical research purposes'.

What will happen to the data collected, and the results of the research project?

After I have analysed the interviews, I will present the findings in my PhD thesis. I may also present them to health care professionals, and the results may be published in journals and presented at conferences. It will not be possible to identify you from any work that I present or publish. Please contact me if you would like a copy of any publications.

Who is organising the research?

I am a PhD student at the University of Sheffield and this study forms part of my PhD programme.

Who is the Data Controller?

The University of Sheffield will act as the Data Controller for this study. This means that [the University] is responsible for looking after your information and using it properly.

Who has ethically reviewed the project?

This project has been ethically approved via the University of Sheffield's Ethics Review Procedure, as administered by the School of Nursing and Midwifery department'

What if something goes wrong and I wish to complain about the research?

If you wish to raise a complaint, you can contact me or Dr. Sharron Hinchliff, Dr. Parveen Ali or Dr. Hilary Piercy. If you feel not satisfied, you can contact the head of

the department, who will then escalate the complaint through the appropriate channels. If your complaint is related to how participants' personal data has been handled, you can provide information on how to create a complaint (the University's Privacy Notice: <https://www.sheffield.ac.uk/govern/data-protection/privacy/general>).

Contact for further information

Please contact me if you have a concern about any aspect of this study. My contact details are at the end of this information sheet.

If you feel that I have not answered your concerns adequately or you would like to speak to someone else, please contact Dr. Sharron Hinchliff Dr. Parveen Ali or Dr. Hilary Piercy. Their contact details are also at the end of this information sheet.

Please do not hesitate to contact me if you would like further information.

Thank-you for your time.

Yours sincerely,

Researcher

Hatice Bulut

The School of Nursing and Midwifery -The University of Sheffield

Barber House, 3a Clarkhouse Road, Sheffield, S10 2LA UK, England

Email: hbulut1@sheffield.ac.uk Tel: 07455 249756

Supervisors

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Senior Lecturer, Programme Lead: MMedSci Advanced Nursing Studies

Associate Editor, Nursing Open

Lead, Sheffield University Interpersonal Violence Research Group

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Dr. Hilary Piercy

PhD, MA, BSc (hons) RGN, RM, PGCE, SFHEA Principal Lecturer

Sheffield Hallam University, Howard Street, Sheffield, S1 1WB

Department of Nursing and Midwifery, Health and Wellbeing

Email: h.piercy@shu.ac.uk Tel: +44 (0)114 225 5555

Appendix 4.4: Consent Form



Example Participant Consent Form

Title of Project: An Interpretative Phenomenological Analysis of postmenopausal women's experiences of menopause, impact on relationship/intimacy and coping methods

Consent Form

<i>Please tick the appropriate boxes</i>	Yes	No
Taking Part in the Project		
I have read and understood the project information sheet dated/...../..... or the project has been fully explained to me. (If you will answer No to this question please do not proceed with this consent form until you are fully aware of what your participation in the project will mean.)	<input type="checkbox"/>	<input type="checkbox"/>
I have been given the opportunity to ask questions about the project.	<input type="checkbox"/>	<input type="checkbox"/>
I agree to take part in the project. I understand that taking part in the project will include completing a demographic questionnaire and being interviewed.	<input type="checkbox"/>	<input type="checkbox"/>
I agree to take part in the project in the following research activities. I give permission for the interviews to be audio recorded. - Skype /equivalent / telephone interview - Face to face interview	<input type="checkbox"/>	<input type="checkbox"/>
I understand that my taking part is voluntary and that I can withdraw from the study during the interview and up to one month after the interview. I do not have to give any reasons for why I no longer want to take part and there will be no adverse consequences if I choose to withdraw.	<input type="checkbox"/>	<input type="checkbox"/>
How my information will be used during and after the project		
I understand my personal details such as name, phone number, address and email address etc. will not be revealed to people outside the project.	<input type="checkbox"/>	<input type="checkbox"/>
I understand and agree that my words may be quoted in publications, reports, web pages, and other research outputs. I understand that I will not be named in these outputs unless I specifically request this.	<input type="checkbox"/>	<input type="checkbox"/>
I understand and agree that other authorised researchers will have access to this data only if they agree to preserve the confidentiality of the information as requested in this form.	<input type="checkbox"/>	<input type="checkbox"/>
I understand and agree that other authorised researchers may use my data in publications, reports, web pages, and other research outputs, only if they agree to preserve the confidentiality of the information as requested in this form.	<input type="checkbox"/>	<input type="checkbox"/>
I give permission for the [specify the data] that I provide to be deposited in [name of data repository] so it can be used for future research and learning	<input type="checkbox"/>	<input type="checkbox"/>
So that the information you provide can be used legally by the researchers		
I agree to assign the copyright I hold in any materials generated as part of this project to The University of Sheffield.	<input type="checkbox"/>	<input type="checkbox"/>

Name of participant [printed]

Signature

Date

Name of Researcher [printed]

Signature

Date

The template of this consent form has been approved by the University of Sheffield Research Ethics Committee and is available to view here: <https://www.sheffield.ac.uk/rs/ethicsandintegrity/ethicspolicy/further-guidance/homepage>



Example Participant Consent Form

Project contact details for further information:

Researcher

Hatice Bulut

The School of Nursing and Midwifery -The University of Sheffield

Barber House, 3a Clark house Road, Sheffield, S10 2LA UK, England

Email: hbulut1@sheffield.ac.uk

Tel: 07455 249756

The template of this consent form has been approved by the University of Sheffield Research Ethics Committee and is available to view here: <https://www.sheffield.ac.uk/rs/ethicsandintegrity/ethicspolicy/further-guidance/homepage>

Appendix 4.5: Photos data collection







Appendix 4.6: Participants interview details

The table showing where, how, what time, and interview duration with the participants is given below.

Participants	Interview place	Interview time	Interview technique	Interview duration
Angela	Home	14:30	In-person	1:30:45
Belinda	University room	17:00	In-person	1:03:07
Camila	Home		In-person	1:12:11
Dawn	Work place	14.00	In-person	46:53
Elizabeth	University room	12:40	Video call interviews-Skype	1:18:32
Fiona	University room	10:30	In-person	Part 1: 56:39 Part 2: 25:02
Gina	Home	15:00	In-person	1:30:42
Helen	Home	14:30	In-person	1:17:56
Isabel	Cafe	09:40	In-person	Part 1- 46:44 Part 2- 16:15
Julie	University room	10:00	Video call interviews-Skype	1:41:11
Kath	University room	10:00	Video call interviews-Skype	59:55
Linda	University room	14:30	In-person	Part 1- 48:25 Part 2- 35:53
Mary	University room	14:30	Video call interviews-Skype	1:15:05
Nancy	Home	10:30	In-person	Part 1- 40:57 Part 2 – 50:28

Appendix 4.7: Demographic data sheet

Participant Identification Number:	
Questions	Answers
Year of birth	
Postcode	
Highest level of Education	
Employment status	
Social class	
Residence Such as; city, rural area...	
Ethnic origin	
Religion	
Children	
Relationship status	
Gender of partner	
Do you have any health condition	
Do you take any medicine	
Menarche age	
Menopause entering time (First started to notice menopause symptoms such as; Irregular periods, Vaginal dryness, Hot flushes, Chills Night sweats, Sleep problems, Mood changes)	

Appendix 4.8 : Demographic information of participants

No	Participants' pseudonym	Age	Location	Education level	Employment status	Social Class	Ethnic Origin	Religion	Children	Relationship status	Gender of partner	Menarche age	Age on entering menopause
1	Angela	51	Sheffield	Undergraduate	Part-time	Working	White British	No	2	Relationship	<i>Past:</i> Bisexual <i>Now:</i> Male	11	49
2	Belinda	49	Nottinghamshire	Master degree	Part-time	Working	White British	No	No	Married	Male	12	42
3	Camila	47	Sheffield	Undergraduate does not finish level 3	Part-time	Working	British Asian	No	2	In a relationship	Male	14	38
4	Dawn	56	Sheffield	College	Full-time	Working	White British	No	2	Divorced	Male	11	39
5	Elizabeth	58	West Sussex	Bachelor	None	Working	White British	No	No	In a relationship	Male	13-14	53

6	Fiona	64	Sheffield	BSC	Full-time	Middle	White British	Christian	No	Married	Male	10	50
7	Gina	57	Sheffield	HND High National Diploma	Part-time	Middle	White British	No	2	Divorced	Male	11-12	50
8	Helen	60	Sheffield	College	Part-time	Middle	White British	Budist	2	Divorced	<i>Past:</i> Male <i>Now:</i> Female	10	50
9	Isabel	49	Wakefield	ACCA Accountancy Professional qualification	Full-time	Working	White British	C-E	No 2 step children	Married	Male	14	45
10	Julie	57	London	First class degree	Retired	Working	White British	Ateist	1	Married	Male	14	51

11	Kath	56	Liverpool	NVQ Level 3	Full-time	Working	White British	Catholic	1	Divorced	Male	11-12	50
12	Linda	56	Sheffield	Master	Self employed Part-time.	Middle	White British	Pagan	1	Married	<i>Past:</i> Male and female <i>Now:</i> Male	12	53
13	Mary	56	Liverpool	A level	Part-time	Middle	White British	No	1	Married	Male	14	54
14	Nancy	59	Sheffield	College	Retired	Working	White British	No	2	Married	Male	14	49

Appendix 4.9: Interview schedule

INTRODUCTION

- Thank the participant for attending.
- Introduce self and clarify the content of the interview
- Go through the information sheet and answer any questions
- Explain confidentiality and gain written consent
- Give participants time to ask any questions and sign the Consent Form.

INTERVIEW

PART A:

1. Are you ready to begin?

- Demographic data sheet

3. Happy to continue?

4. Can you please tell me how did you hear about this study?

5. What first came to your mind when you saw the interview subject?

6. Can I ask you what did you find interesting about the study and how did you decide to take part?

PART B:

7. Have you had conversations with others about menopause? If yes, who?

Prompts: friends, partner or healthcare providers like a nurse or GP on menopause issues (complaints)?

If so, how did they go?

Are you/were you comfortable discussing it? Who would you feel most comfortable discussing it with.

8. Have you had knowledge of menopause? If so, where did you get information and from whom?

Have you experienced any menopause symptoms?

If so, what symptoms.

Have you sought help for menopause symptoms?

If so where from.

9. Did you get help / support from anyone?

PART C:

10. Can you describe what menopause means to you? Or What does "menopause" mean for you?

11. What are your feelings about menopause?

12. Can you tell me about your experience of menopause?

What symptoms or signs of menopause have you experienced?

Prompts: Irregular period, vaginal dryness, hot flushes, chills, night sweats, sleep problems, mood changes, weight gain and slowed metabolism, thinning hair and dry skin, loss of breast fullness, irregular heartbeat...)

13. How did you feel when you learned that you are experiencing menopause?

14. What ways can menopause impact on women's lives?

Has it had an impact on your life? If so, in what way(s)?

15. Do you think the menopause can affect a woman's relationship with her husband or partner?

16. Can you tell me have you had any changes in your relationship since entering menopause? What do you think that they might be related to menopause?

Prompts: What are the main differences in your relationship after entering menopause? impact on sexuality, body image—women's perceptions of their sexuality and sexual relationships

17. Do you think is there any relation between menopause and sexual changes?

e.g. Has menopause changed your sex life?

If yes, in what way?

Prompt: sexual desire, sexual arousal, vaginal issues such as dryness, pain

Other related issues such as fatigue, mental health e.g. anxiety or depression

18. Do you consider the change(s) to be a sexual problem?

19. Have you done anything to overcome these changes / difficulties?

20. How do you cope with changing sexual life/ sexual changes and difficulties after entering menopause?

If you were to give advice to other women in your situation, what would it be?

PART D:

21. Is there anything else you would like to tell me or to add?

22. Do you know of any other women who might be interested in taking part in the study?

Thank-you for your time

General Probes

- Could you tell me a bit more about that?
- Can you give me an example?
- Do you mean that...?
- What do you mean by...?
- Can you explain that a little more?
- How did you feel?
- What was that like for you?
- How so?

This is not a strict interview schedule to be adhered to because the interviews will be semi-structured. The researcher will add questions and additional probes as they find appropriate and as areas of interest develop.

Appendix 4.10: Reflection diary

Post-interview reflection diary

Date: 31.05.2019

	Participant information	Participant number: 1 Interview type: Face to face Age: 51 Relationship status: Has a male partner
1	Interview place	I went to the woman's house; it was quite far, but I had no difficulty finding the house. She welcomed me positively.
	Date and time	31.05 2019 - 14.30
	How did you decide where and when to meet?	We decided where and when we would meet after answering many emails and questions in her mind.
2	How long was the interview?	1:30:46
3	Interruptions; telephone, partner, grandchildren and so on	There was no significant interruption to our meeting, except for minor circumstances. Sometimes she left the room to get her vitamins and devices to show me, but she returned quickly. She also left the room for a short time to let her dog out because it was barking.
4	My feeling as a researcher	I was a little excited and worried about how to get answers to my questions because she was the first real participant.

	<p>Was I comfortable?</p> <p>Did you use verbal utterance for example: 'right', 'that makes sense'?</p> <p>Did you ask all the questions?</p>	<p>However, I tried not to reflect this concern as much as I could during the meeting and I always acted with a smile for the woman to be more positive and to trust me.</p> <p>From time to time I shook my head and supported her comments to show that I was listening to the participant as much as possible and tried to show that I understood her feelings.</p> <p>I tried to ask all my questions, but when I found out that the woman had a lesbian relationship, I did not know what to say for a short time and I was afraid of a false reaction. I did not make any negative comments about it. I did not judge her and I regarded this as a very normal situation.</p>
--	--	---

5	Which subject was challenging for you?	It was difficult for me the first few minutes after I learned that she had a lesbian relationship because I was not sure about whether I should ask her about this issue in detail.
6	Which subject was challenging for the participant	She seemed to relax during the interview, but when she was talking about sexuality I felt that she had some difficulties and I thought that she did not want to give too much detail, but as the meeting progressed, I felt she trusted me and kept talking to me more comfortably.
7	Participant comfortable or not?	She was comfortable in general and she explained her feelings as much as possible.
8	Participant's feelings	She said that her insomnia problem affected her very much. She mentioned that her daughter had prepared a surprise birthday party for her, but said that she could not fully join the party because of the insomnia and felt bad about it. Her eyes were full and she almost cried. I was also affected by this situation. She mentioned that she had a happy relationship; I felt that her relationship with her partner was positive.
9	Compared with the other participants	It was my first meeting. We talked as much as possible, but I could learn more about what kind of things were talked about with friends.
10	Extra Notes	

Appendix 4.11: Notes for participant

Angela First participant

Part 1

1. Important Words and Notes from participant sentences

- Heavy bleeding
- Insomnia- work life difficult- reduce work hour
- Menopause meaning without pregnancy
- Golden years
- I feel really sad
- Grumpy
- shouted to daughter

1.1 Used alternative medicine

- **NYTOL** – for insomnia



- Hypnosis
- Cod liver oil



Cod liver oil is an excellent source of nutrients, and it may have some important therapeutic properties. It is thought to help relieve joint stiffness associated with arthritis, have a positive effect on cardiovascular health, and help repair damaged teeth, nails, **hair**, and skin.

- **Primrose oil**

Women also use evening **primrose oil** for premenstrual syndrome (PMS), breast pain, endometriosis, and symptoms of menopause such as hot flashes. In foods, evening **primrose oil** is **used as** a dietary source of essential fatty acids.

- **Omega 3 Fish oil.**

Part 2

1. Important Words and Notes from participant sentences

- I have two children however in between those children my relationships were with women.
- My comment: I was shocked when I heard this sentence
- I call menopause reverse puberty
- As I suppose the sexual changes and menopause are that I want to have more sex now than I have done in the past so I have more sex now than at any point in my entire life. So then menopause has given me more of a sex drive
- HRT we talked a lot about it
- Norethisterone SHE DIDNOT USE IT

1.1 Used medicine

- Mirena coil fitted

1.2. Kegel weights



Camila Third participant

Part 1:

1. Important Words and Notes from participant sentences

- Lower mood: life is good is no reason (Nancy use the same sentence I remember)
- Hot flushes
- Sleep problem
- Bladder problem
- She think that Exceptional because of france
- She has friend Gp
- Irritable (14 .part says the same thing)
- Stigma

1.1 Used medicine:

1.1.1 Montelukast sodium tablet 28x10 mg



What is montelukast tablets used for?

Montelukast oral tablet is used to prevent and treat symptoms of asthma and seasonal or year-round allergies.

1.1.2 Black cohosh

HOME / BLACK COHOSH



PRODUCT		INFO
BLACK COHOSH		
Product Code: 09CO		
Size	Price	
100g	£12.23	
250g	£27.00	
500g	£49.09	
1kg	£88.54	
10kg	£619.79	

Black cohosh is an herb. The root of this herb is used for medicinal purposes. Black cohosh was first used for medicinal purposes by Native American Indians, who

introduced it to European colonists. Black cohosh became a popular treatment for women's health issues in Europe in the mid-1950s.



How does it work?

The root of black cohosh is used for medicinal purposes. Black cohosh root contains several chemicals that might have effects in the body. Some of these chemicals work on the immune system and might affect the body's defenses against diseases. Some might help the body to reduce inflammation. Other chemicals in black cohosh root might work in nerves and in the brain. These chemicals might work similar to another chemical in the brain called serotonin. Scientists call this type of chemical a neurotransmitter because it helps the brain send messages to other parts of the body.

Black cohosh root also seems to have some effects similar to the female hormone, estrogen. In some parts of the body, black cohosh might increase the effects of estrogen. In other parts of the body, black cohosh might decrease the effects of estrogen. Estrogen itself has various effects in different parts of the body. Estrogen also has different effects in people at different stages of life. Black cohosh should not be thought of as an "herbal estrogen" or a substitute for estrogen. It is more accurate to think of it as an herb that acts similar to estrogen in some people.

Since that time, black cohosh has commonly been used to treat symptoms of menopause, premenstrual syndrome (PMS), painful menstruation, acne, weakened bones (osteoporosis), and for starting labor in pregnant women.

Uses & Effectiveness?

Possibly Effective for Menopausal symptoms

Research shows that taking some black cohosh products can reduce some symptoms of menopause. However, the benefits are only modest. Black cohosh might lessen the frequency of hot flashes. Most of this research is for a specific commercial black cohosh product, Remifemin. The benefits may not occur with all products that contain black cohosh. Research using black cohosh products other than Remifemin have not always shown benefits for menopausal symptoms. Some of these studies show that these other black cohosh products do not reduce hot flashes or menopausal symptoms any better than a sugar pill ("placebo"). Some women take black cohosh for hot flashes related to breast cancer treatment. Women with breast cancer should not use black cohosh without talking to their cancer specialist or other health provider. Some early research suggested that black cohosh might reduce hot flashes in breast cancer patients, but more recent and higher quality research shows that black cohosh does not reduce hot flashes in women with breast cancer. Also, there is some question as to whether black cohosh is safe for women with breast cancer. It is important for a woman with breast cancer to discuss any use of black cohosh with her health provider before using it.

1.2 HRT

1.2.1 Elleste solo

1mg tablet 28 mg

Elleste Solo (Estradiol Hemihydrate) 1mg 84 Tablets is a Hormone Replacement Therapy (HRT). The active ingredient is the female hormone Oestrogen: Estradiol Hemihydrate 1mg. **Elleste Solo** is used for relief of symptoms occurring after menopause and prevention of osteoporosis.

1.3 IUD

An intrauterine device (IUD), also known as intrauterine contraceptive device (IUCD or ICD) or coil,[3] is a small, often T-shaped birth control device that is inserted into a woman's uterus to prevent pregnancy

1.4. Mirena coil

1.5. Menopause matter website

She looked this website to get information

<https://www.menopausematters.co.uk/>



The screenshot shows the homepage of the Menopause Matters website. At the top right, there are social media icons for Twitter, Facebook, Instagram, and YouTube. The main logo reads "Menopause matters" in a mix of pink and blue fonts. Below the logo is a pink navigation bar with links: Home | About | Surveys | Specialists | Forum | Professionals | Sitemap | Shop | Contact. A search bar is located below the navigation bar. The main content area features a large banner with the text "Welcome to Menopause Matters.co.uk" and a sub-headline "Menopause matters.co.uk is an award winning, independent website providing up-to-date, accurate information about the menopause, menopausal symptoms and treatment options. Here you will find...". To the left of the banner is a promotional graphic for a subscription: "subscribe today for a year from just £25!". To the right is a sidebar titled "For your information..." with a list of categories: "> Menopause +", "> Premature Menopause +", and "> Menopause Symptoms +".

Appendix 4.12: Transcription notations used

Symbols	Meaning
[]	Some brief information be added to explain what the participant is talking about Confidentiality; [date of birth] [place name] etc.
()	Explanatory material added by interviewer such as (laughs) etc.
<u>Underline</u>	When they speak loudly
Bold	When they emphasise
CAPITALS	When they shout
(3)	When they pause, number represents length of pause in seconds
xxx	When researcher have missed some talk out as it isn't relevant
...	When they do not finish sentence
Yellow colour	Listen again
Green colour	Important place
Explanation	Red colour
Comment	Red colour

Appendix 4.13: Sample of data analysis

Superordinate theme: Sexual Changes

Subordinate theme: Sexual desire

Angela 1st participant				
Superordinate theme	Subordinate theme	Emergent themes	Transcription extract	Exploratory comments
SEXUAL CHANGES	SEXUAL DESIRE			

Reference 1

			- Interviewer:	
			Desire.	
			- Angela:	
SEXUAL CHANGES	SEXUAL DESIRE	Belief that Menopause affects desire	Yeah. It affects my desire. Yeah.	D: Affects desire

Reference 2

			- Interviewer:	
			Sometimes increase or sometimes decrease?	
			- Angela:	
SEXUAL CHANGES	SEXUAL DESIRE	Decreased desire	Sometimes decrease, yes.	D: Decrease desire

Reference 3

			- Interviewer:	
			Generally, decrease or increase; what do you think?	
			- Angela:	
SEXUAL CHANGES	SEXUAL DESIRE	Increased and decreased desire together	Erm... I think, now. For the past two months decrease, before that increase.	D: Increased and decreased desire together

Reference 4

			- Interviewer:	
			What do you think why decrease?	
			[00:53:20.800] - Angela:	
SEXUAL CHANGES	SEXUAL DESIRE	Reasons for decreased desire: vaginal dryness and brain fog	I think we go back to the vaginal dryness. [I: Hmm]. Yeah. Sometimes, I don't feel like things are right down there and sometimes I feel like brain fog in my head and I can't think about anything other than this fog. I can't see through the fog in my mind to want to be intimate. Does that make sense?	D: Reasons for decreased desire: vaginal dryness and brain fog

Reference 5

			- Interviewer:	
			Can you explain a bit more about that?	
			- Angela:	
			I can't see a way to be intimate in my head	D: No thinking intimate in her head

Appendix 4.14: Letter of approval from University Ethics



Downloaded: 18/04/2019
Approved: 18/04/2019

Hatice Bulut
Registration number: 170218267
School of Nursing and Midwifery
Programme: School of Nursing and Midwifery

Dear Hatice

PROJECT TITLE: An Interpretative Phenomenological Analysis of postmenopausal women's experiences of menopause, impact on relationship/intimacy and coping methods

APPLICATION: Reference Number 024455

On behalf of the University ethics reviewers who reviewed your project, I am pleased to inform you that on 18/04/2019 the above-named project was **approved** on ethics grounds, on the basis that you will adhere to the following documentation that you submitted for ethics review:

- University research ethics application form 024455 (dated 13/04/2019).
- Participant information sheet 1057339 version 3 (12/04/2019).
- Participant consent form 1057342 version 2 (12/04/2019).

If during the course of the project you need to [deviate significantly from the above-approved documentation](#) please inform me since written approval will be required.

Yours sincerely

Kate Chadwick
Ethics Administrator
School of Nursing and Midwifery

Appendix 4.15: Letter of approval for minor amendment to ethics submission

University of Sheffield Mail - Re: Ethics minor amendment form

<https://mail.google.com/mail/u/0?ik=c0217ddfc8&view=pt&search=all>



Kate E Chadwick <k.chadwick@sheffield.ac.uk>

Re: Ethics minor amendment form

1 message

Angela Tod <a.tod@sheffield.ac.uk>

16 May 2019 at 11:45

To: Kate E Chadwick <k.chadwick@sheffield.ac.uk>

Hi Kate

I am happy with these amendments. They appear well thought through and considered

Thanks

Angela

Sent from my iPhone

On 16 May 2019, at 11:32, Kate E Chadwick <k.chadwick@sheffield.ac.uk> wrote:

Hi Angela

Earlier in the year you were lead reviewer on an application from Hatice Bulut. The application was approved but Hatice has submitted a minor amendment to the application - please see email below and attachments.

As lead reviewer, could you please confirm if you are happy with the suggested changes? If so, I will note them on the online system and attach Hatice's amendment form and documents to her original application.

Hatice is keen to start the interviews asap. I have made Hatice aware that you're out of the office until next Tuesday, and advised her that we will get back to her as soon as possible.

Thanks,
Kate

----- Forwarded message -----

From: **Hatice Bulut** <hbulut1@sheffield.ac.uk>

Date: Wed, 15 May 2019 at 09:43

Subject: Re: Ethics minor amendment form

To: Rachel L King <rachel.king@sheffield.ac.uk>

Cc: Jane McKeown <j.mckeown@sheffield.ac.uk>, Kate E Chadwick <k.chadwick@sheffield.ac.uk>

Dear Kate and Rachel

I completed my ethics minor amendment form. I updated my participant information sheet and consent form according to my changing.

I attached them to this email.

Is there anything else, I need to do?

Thanks in advance.

Best regards,

Hatice

On Fri, 3 May 2019 at 16:31, Rachel L King <rachel.king@sheffield.ac.uk> wrote:

Hi Hatice,

yes you will need to complete the amendment form. You will also need to add the new method of data collection to the protocol, information sheet and consent form.

Ethics minor amendment form

Kate E Chadwick <k.chadwick@sheffield.ac.uk>

23 May 2019 at 13:34

To: Hatice Bulut <hbulut1@sheffield.ac.uk>

Cc: Sharron Hinchliff <s.hinchliff@sheffield.ac.uk>, Parveen A Ali <parveen.ali@sheffield.ac.uk>, H.Piercy@shu.ac.uk

Dear Hatice

Following on from our earlier conversation, this email is to clarify that you have received approval for your minor amendments recently submitted (as detailed on the attached form).


This confirmation was originally sent to you, by email, on the 16th May.

I hope this is helpful. I have copied your supervisors into this email so they are also aware.

Please do not hesitate to contact me again if you have any further questions.

Best wishes,

[Quoted text hidden]

 **Bulut, H - Minor Amendments 16.05.19.docx**
35K

Appendix 4.16: Information Sheet

Information Sheet

If you need help and further information, you can get help and information from the following organization list.

1. Age, sex and you

Website: <http://www.agesexandyou.com/>

2. The British Menopause Society (BMS)

Website: <https://thebms.org.uk/>

3. Menopause Support

Website: <https://menopausesupport.co.uk/>

4. My Menopause Doctor

Website: <https://www.menopausedoctor.co.uk/>

5. Relate

Website: <https://www.relate.org.uk/>