RESEARCH

Women's decision making at menopause

A focus group study

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BACKGROUND
Women are faced with a confusion of information and uncertainty when making decisions at menopause.

METHODS
We conducted four focus groups of 31 women aged 40–64 years, exploring their experience and views about menopause, its management, and decision support needs.

RESULTS
Focus group participants saw menopause as a natural progression rather than a medical condition, and decision making about therapies as a personal responsibility. They wanted reliable, agenda free information, and opportunities to discuss personal needs with (preferably female) health professionals. They preferred minimal intervention and found life style strategies helpful.

DISCUSSION
Women's preference to make their own decisions at menopause is frustrated by conflicting information and the perceived marketing agenda of information sources. Women need unbiased, timely, menopause information backed by expert commentary in a range of media to suit their access needs.

Decision making at menopause is currently complex. Women's awareness of potential risks has been raised by recent controlled trials[1,2] and the consequent media debate about hormone therapy (HT) at a time of increasing long term HT use.[3] This highlights both uncertainty in the shifting evidence base and differences in its interpretation among experts.[4] Underlying this are differences in attitude – between the perspectives of seeing menopause as either a biomedical deficiency state[5,6] or, as women do, as a natural progression.[6,7]

Women are increasingly taking responsibility for their own health decision making[8,9] and expect information to support their choices.[10] Existing menopause decision aids tend to assume deciding between two choices: to use or not use HT.[10] Women's current therapy choices[11] indicate there may be an additional need for decision supports which incorporate information and evidence for alternative therapies and lifestyle interventions.

Methods

Focus groups were conducted with women aged 40–64 years who were sampled purposively by recruiting through email university academic and nonacademic staff, and by distributing flyers within community groups in southern Adelaide (South Australia). Recruitment attempted to include women with and without both employment and access to computers, relevant to assessing menopause information media preferences, but tried to preserve homogeneity among women within each group to encourage optimal participation.[12] Recruiting women seeking medical support for menopause issues was deliberately avoided. Women were paid $20.00 toward travel costs.

A phenomenological, grounded theory approach[13,14] was used, incorporating a discursive exploration of the women's experience and views about:

- menopause and aging
- menopause therapy
- influences on decision making
- menopause information

- information media, and
- desirable attributes of resources to aid decision making.

Discussions were audiotaped, transcribed and analysed systematically by two independent researchers to identify themes using an established method.[14] Anomalies and differences were noted and further scrutinised for meaning.

Ethics approval was granted by Flinders University Social and Behavioural Ethics Committee.

Results

Four focus groups ranged in size from 6–9 women (n=31) aged 40–64 (mean 53) years. They reported varying current work status, and a wide range of menopause status and related symptom experience. Although saturation of themes was reached early, all four focus groups were completed (two each in university and community settings) to minimise bias (*Table 1*).

Focus group participants identified a predominantly negative social view of menopause and aging which could be addressed by public media strategies. They saw a related gap in nonmedical information addressing influential midlife stress factors (eg. changing

Table 1. Emerging themes from focus groups

Sociocultural factors

Focus group participants:
- perceived menopause to have a negative sociocultural image
- perceived menopause to have a low public profile
- reported experiencing performance anxiety related to negative sociocultural perceptions of aging (working women particularly)
- saw a need for positive and supportive models for aging

'It's the same old stuff about, you know, the super woman, having to have the gorgeous family and the fabulous job, and how does [the Vice Chancellor] manage her menopause?'

Midlife experience and life style techniques

Participants:
- viewed menopause as a natural progression in the lifecycle not a biomedical condition
- attributed stress to life circumstances as much as to menopause
- found exercise and yoga helpful in managing emotional and stress aspects of midlife

'Obviously it's your lifestyle, what other factors in your life, how much stress you've got, how much support you've got...'

'I'm still waiting to feel old... so I'm cramming everything in, but I also do relaxation and yoga and can be mentally and physically totally relaxed'

Scepticism

Participants:
- were suspicious of the influence of drug companies on social and medical views
- viewed much available information as agenda laden

'There's no such thing as 'neutral information'

Decision making resources

Participants:
- saw decision making about health, menopause management and therapy use as a personal responsibility
- wanted reliable resources to allow independent research for personally relevant information
- wanted to receive information before they reached menopause
- were confused by conflicting information
- were largely unaware of reliable sources
- mostly accessed information through popular press
- had varying access to and preference for information media

'If it's about HT... it's all very well for doctor to say: 'Oh yeah, take that'. But whose body is it? It's your body. And I think you need to get all the information'

'It's critical that information is current, in easily digestible form, and assessed by someone who doesn't have an agenda'

Health professionals

Participants:
- wanted GPs to assist decision making by presenting a comprehensive range of menopause information including:
  - self management practices
  - alternative options or referral
  - acknowledgment of therapy risks and referral to reliable risk information
- appreciated acknowledgment of evidence uncertainty
- wanted adequate time for discussion
- preferred female practitioners for menopause issues
- preferred 'natural' treatments
- preferred the least possible effective level of therapy if necessary
- preferred targeted therapy

'I'd love to have talked longer [about my situation], but you just don't want to wear [GPs] out, they're so busy'

'The problem is... we all have really individual chemistry and what works for one person doesn't necessarily work for someone else'

Personal/intimate issues

Participants:
- talked openly about sexual intercourse
- related interest in sex to relationship quality and other midlife factors
- were reticent about continence issues

'I think I experienced a loss of interest [in sex], but I also think it was to do with the relationship I was in... the relationship was in trouble and my father died, and I had a responsible job, so there was a whole heap of stuff going on'

self perception, maintaining confidence at work, supporting aging parents, and relationship factors) which could be addressed by strategies such as women's forums and public media events featuring high profile women where successful management techniques for such experiences could be shared. Participants saw these strategies to be of potential benefit to both the public image of menopause and to women's approach to healthy aging.

Participants were sceptical about the reliability of available information, largely owing to a perception of the influence of marketing by drug companies to health professionals and through the media. Similarly, participants were wary because of their general practitioners past advocacy for HT. Despite the expressed need for more reliable information, most reported using sources which were at the lower end of the information hierarchy (eg. women's magazines, newspapers, and television).[15] Few participants knew how to find or access more reliable information. Only some were frequent computer users, yet all recognised the value of reliable websites as being likely to maintain currency of information about health strategies, local services, and expert opinion. They proposed telephone hotlines for computer nonusers. Most women were unaware of existing reliable websites and call centres.

Participants identified a need for time for discussion with health practitioners. They often did not pursue issues perceived to be burdensome because of time pressure, which led to miscommunication with GPs. Some, for example, reported leaving a consultation with a prescription for HT they had no intention of filling, along with a sense of frustration at miscommunication and time wasted. Women who chose alternative health practitioners did so partly because they had confidence in targeted therapy advice given after having adequate time for discussion.

Discussion

These findings using focused sampling include the views of English speaking women who either work or participate in community groups. Women who are more isolated socially, linguistically, or physically are not represented and their views and needs may be different in type and degree from those discussed in this study.

Our findings support several previous studies showing that conditions often attributed to menopause have psychological and environmental rather than hormonal triggers.[16–19]

This study adds to previous findings by demonstrating women's preference for minimal intervention and for lifestyle methods to manage symptoms and contribute to wellbeing at menopause and beyond. There may be scope for promoting practices such as exercise, yoga, and meditation as long term self management strategies by health practitioners, public health bodies, and employers.

Women's preference for women doctors in menopause matters could be explained by women expecting better empathy from other women. Similarly, their comfort in discussing sexual issues may have resulted from the female profile of the focus groups. However, reticence to discuss incontinence, (a common menopause symptom) suggests that practitioners might need to raise the topic directly to ensure any problems are addressed and to normalise the experience.

These results will be incorporated into a randomised controlled trial, investigating the extent to which using decision aids improves women's understanding and confidence in decision making about approaches to menopause and healthy aging.

Implications for general practice

- Focus groups identified that GPs might support women's decision making better by:
  - providing more time for dialogue
  - addressing menopause in the broad context of midlife change (especially life events)
  - considering all health related treatments including alternative treatments and lifestyle changes
  - providing current, inclusive information (print and web based) in the practice setting
  - raising continence problem (rarely volunteered)
  - providing a woman health practitioner
  - avoiding the 'myth of certainty around what is inherently uncertain' when discussing therapy.

Conflict of interest: none declared.

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