THE LIVED EXPERIENCES OF PERIMENOPAUSAL CHRISTIAN WOMEN: A QUALITATIVE PHENOMENOLOGICAL STUDY

by Sheri Collinsworth Cobarruvias

Liberty University

A Dissertation Presented in Partial Fulfillment of the Requirements for the Degree Doctor of Philosophy

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APPROVED BY:

Deborah Ann Braboy, Ph.D., Committee Chair

Sonya Cheyne, Ph.D., Committee Member

Joy Mwendwa, Ph.D., Committee Member

ABSTRACT

Perimenopause (PM) is a natural physiological process indicating the start of the non-reproductive phase of a woman's life, which is a significant life event and a global health issue that affects millions of women worldwide. PM produces the most physiological changes in a woman's body than the other phases of menopause. This qualitative study explores the lived experiences of PM Christian women from a bio-psycho-social-spiritual perspective through the lens of feminist theory. Data were gathered through virtual semistructured personal interviews with a sample of 10 participants focused on their physical, biological, psychological, emotional, mental, cognitive, social, relational, and religious/spiritual experiences during PM, with self-identity, coping strategies, and protective factors taken into consideration. Findings underscored participants' bio-psycho-social-spiritual functioning, challenges to self-identity, self-isolation, the impact of limited knowledge about PM and the need for PM education and support, the benefits of communication to destigmatize PM, and the influence of coping skills and protective factors. Recommendations were made for PM Christian women, their personal support systems, community care organizations, medical and mental health professionals, and counselor educators. With greater communication, knowledge, professional and social support, increased menopause education for medical and mental health professionals, and understanding the needs of PM Christian women, the barriers to effective treatment along with the stigma of PM can begin to be addressed. This study bridges a gap in the literature concerning PM in that Christian women's voices are heard and their experiences shared. Future research is indicated for more inclusive and relevant treatment.

Keywords: perimenopause, menopausal transition, women's mental health in midlife, menopause awareness, end stigma of menopause

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Dedication

First, and foremost, this dissertation is dedicated to God, the Father Almighty, and Jesus Christ, my Lord and Savior, without whom I would not have gotten to this point. “I can do all things [which He has called me to do] through Him who strengthens and empowers me [to fulfill His purpose—I am self-sufficient in Christ’s sufficiency; I am ready for anything and equal to anything through Him who infuses me with inner strength and confident peace.]” Philippians 4:13 AMP

I dedicate this dissertation in memory of my maternal grandparents, James and Betty Stahl, I love you and miss you every day and I am so appreciative of the love and support you always gave me. I also dedicate this dissertation in memory of my paternal grandparents, John and Eunice Collinsworth, you enabled me to have life. I wish I had had the chance to grow up with you and know you better. Lastly, I dedicate this dissertation in memory of my maternal grandparents-in-law, Antonio and Ruth (Ita) Molano, you welcomed me into your family from the very beginning and loved me like a granddaughter. Thank you!

This dissertation is dedicated in honor of so many people who have provided their undying support, prayers, love, and encouragement. I am so very thankful God blessed me with having these people in my life. Without each you, I do not know where I would be… Thank you!

Thank you to the following…	
To my husband, parents, and parents-in-law – "Thank you" does not seem like enough for all you mean to me. You all have done so much to support me in this journey by praying for me, encouraging me, cheering me on, easing my load, giving me space to work or rest, and so much more! I am truly grateful God blessed me with each of you in my life.	
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Supervisees (Current and Former) **Texas LPC-Associates** **Virginia Residents in Counseling** **Graduate Counselors in Training**	Thank you for choosing me and allowing me to be your supervisor and for putting up with me. I have greatly valued our experiences together. I have learned so much from our experiences together and I am very proud of the work you are doing and to call you colleagues.
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Family	Thank you for your undying support, encouragement, and love.
Friends	Your love and support has meant so much to me on this journey. I know I have not always been the best at keeping in contact or spending time together, but I greatly appreciate that you are there for me and always will be. Thank you!
For those who have been on this journey with me since before the beginning, I thank you that you are still on this journey with me. For those who I met during this journey, I am so glad God allowed us to cross paths and I look forward to what the future holds.	
I wish I could name everyone who has been on this journey individually, but I do not want to leave anyone out or hurt anyone's feelings. I thank you all for being there for me. This was not a journey I could do alone. We are made social beings for a reason. It is all part of God's design. I love you all! Thank you!	

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Additionally, I would like to thank a dear friend and colleague, Dr. Amanda Strivings, whose enthusiasm and electric spirit was an absolute godsend at just the right moment in this process. I appreciate your insights very much. Your persistence, guidance, and feedback were very helpful.

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List of Abbreviations

Acceptance and commitment therapy (ACT)

American Counseling Association (ACA)

Counsel for Accreditation of Counseling and Related Educational Programs (CACREP)

Clinical mental health counseling (CMHC)

Cognitive behavioral therapy (CBT)

Continuing education unit (CEU)

Institutional review board (IRB)

Mindfulness-based cognitive therapy (MBCBT)

Menopausal processes (MP)

Menopausal transition (MT)

Perimenopause (PM)

Poly cystic ovarian syndrome (PCOS)

Premenstrual dysphoric disorder (PMDD)

Premenstrual syndrome (PMS)

Religious/spiritual (R/S)

Research question (RQ)

United Nations Fund for Population Activities (UNFPA)

CHAPTER ONE: INTRODUCTION

Overview

The menopausal transition (MT), also known as "perimenopause" (PM) is the events that occur in a woman's body leading up to menopause, which occurs 1 full year and a day after a woman's last menstrual period without the assistance of hormonal contraception or surgical procedures (Delamater & Santoro, 2018; Elavsky, & McAuley, 2007; Gordon-Elliott et al., 2017; Hunt, 2016; Mauas et al., 2014; Sandilyan & Dening, 2011). Menopause is a natural biological process, a significant life event, and a global health concern signaling the beginning of the nonreproductive stage of a woman's life, which includes physical and psychological health problems (Delamater & Santoro, 2018; Elavsky & McAuley, 2007; Gordon-Elliott et al., 2017; Hunt, 2016; Kopciuch et al., 2017; Mauas et al., 2014; Onder & Batigun, 2016; Rindner et al., 2017; Sandilyan & Dening, 2011). The stages of menopause consist of premenopause or premature menopause, PM or MT, menopause, and postmenopause, which are natural biological processes heralding the end of fertility (childbearing), occurring between a woman's early 30s to 60s, resulting in physical, social, and often psychological changes (Onder & Batigun, 2016; Sandilyan & Dening, 2011; Sharma & Mahajan, 2015). These are part of the menopausal process (MP; Hunt, 2016; Sherman, 2005). MPs are significant life events that are experienced by millions of women globally, posing substantial health issues requiring further inquiry into effective treatments (Hunt, 2016; Muharam et al., 2018; Onder & Batigun, 2016; Sandilyan & Dening, 2011; Sharma & Mahajan, 2015).

This study was designed to explore the lived experiences of PM Christian women from a bio-psycho-social-spiritual perspective. Physical (e.g., hot flushes, heart issues, sleep disturbances, muscle and joint discomfort, feeling tired or rundown, sexual problems, and

urinary issues) and social (e.g., social withdrawal, avoidance, and changes in social circumstances such as marital separation or divorce) changes experienced during the MT can often lead to increased psychological symptoms (e.g., depressed mood, low energy, irritability, anxiety, and mental exhaustion) that if left untreated resulting in decreased quality of life (Frey et al., 2013; Sandilyan & Dening, 2011; Sharma & Mahajan, 2015). Data collection focused on self-identity before and after the commencement of symptoms; physical, emotional, social, and spiritual symptom identification as well as positive and negative coping strategies used with the goal of determining how the mental health profession can advocate for PM Christian women.

Background: MP

Understanding MP is critical, but there is conflicting information concerning the terminology surrounding menopause, the number of stages, and the length of the stages. This section will describe all stages of MP, including specific characteristics, general age of onset, and length of duration for each phase. For simplicity, the age and time frames are for women who go through natural menopause (i.e., no medical or surgical interference) and are not exact. The following sections will briefly describe each stage in the MP (pre-, peri-, post-menopause).

Premenopause or Premature Menopause

Terms such as “premenopause” or “premature or early menopause” are often used to mean the same construct; however, these concepts are not the same. According to the North American Menopause Society (2021), premenopause begins at the onset of puberty (first menstrual period) to PM or the MT. Premature menopause or early menopause is the cessation of menstrual periods before the age of 40 or 45, respectively, either by natural or medical means (Office on Women’s Health, 2018). During premenopause, no symptoms of peri- or postmenopause are present; menstrual periods can be regular or irregular (no noticeable

changes), occurring during the reproductive years; and minor hormonal changes may occur, but no physical changes have arisen (Bromberger et al., 2001, 2007; Chedraui et al., 2007; Freeman et al., 2004, 2006; Grochans et al, 2018; Nall, 2021; Tangen & Mykletun, 2008; Treloar, 1981). Common symptoms experienced during premenopause include abdominal cramping, mood swings, anxiety, depression, irritability, and other symptoms associated with premenstrual syndrome (PMS; Nall, 2021).

PM or MT

The PM stage, actually known as the MT, begins in a woman's late 30s through late 50s, signaled by frequent hormonal changes (i.e., estrogen, follicle-stimulating hormone, testosterone, progesterone) leading to the cessation of the menstrual cycle and the nonreproductive stage of a woman's life (Bromberger et al., 2018; Delamater & Santoro, 2018; Elavsky, & McAuley, 2007; Gordon-Elliott et al., 2017; Mauas et al., 2014; Nall, 2021; Sandilyan & Dening, 2011). During the MT, symptoms that can be experienced include vasomotor changes (e.g., hot flashes, night sweats, sleep disturbances), cognitive (e.g., memory lapses, confusion, forgetfulness), metabolic changes (e.g., decreased metabolism, less energy), somatic changes (e.g., body aches, pains, headaches, insomnia), and psychological changes (e.g., irregular mood, irritability, hostility, depression, anxiety; Becker et al., 2007; Delamater & Santoro, 2018; Elavsky, & McAuley, 2007; Gibbs et al., 2013; Gordon-Elliott et al., 2017; Grochans et al., 2018; Hunt, 2016; Jagtap et al., 2016; Levin, 2015; Mauas et al., 2014; Nall, 2021; Sandilyan & Dening, 2011). Healthcare professionals are encouraged to understand the symptoms of PM to guide treatment management for their patients (Delamater & Santoro, 2018).

Postmenopause

The postmenopausal stage occurs in a woman's late 50s+ and begins 1 year after her last

menstrual period without hormonal contraceptives or surgical removal of ovaries and uterus (Grochans et al., 2018; Hunt, 2016; Jafari et al., 2014). Symptoms are similar to the PM phase, which lessen over time; however, they may be compounded by external life stressors of midlife, such as looking after aging parents, late adolescent or adult children going off to college and leaving home, relationship issues, work, financial concerns (Grochans et al., 2018; Hunt, 2016; Jafari et al., 2014). Due to longer life expectancy, women will spend up to a third of their life in postmenopause. Physical symptoms to be aware of in postmenopausal include decreased hormone levels resulting in an increased risk for osteoporosis and heart disease, cognitive decline, and decreased physical functioning (Anderson et al., 2014; Hunt, 2016; Sharma & Mahajan, 2015)

Situation to Self

Phenomenological research is used to develop concrete understandings of events or phenomena through the lens of lived experience from the participants (Flood, 2010; Hays & Wood, 2011; Mapp, 2008; McLeod, 2011; Moustakas, 1994; Neubauer et al., 2019; Patton, 2002; Wertz, 2005). Part of the process of qualitative phenomenological research is for the researcher to "bracket themselves off" (known as epoché or setting aside one's prejudgments) with concern to preconceived ideas of the phenomenon under investigation. Interest in the topic for this study originated as a result of the researcher's struggles, frustrations, and triumphs while going through the MT over the last 10 years. Due to personal experience with the MT, the researcher has developed their ideas and biases concerning physical and psychological symptoms, experiences with medical and mental health personnel, and how they interact and view the world around them. Some of the researcher's experiences with the MT include many of the common physical, psychological, social, and spiritual symptoms and difficulties associated

with the MT (e.g., brain fog, fatigue, lack of interest, self-isolation, sadness, weight gain, problems concentrating, depression, anxiety).

Due to their own experience with PM, listening to friends, family, and others on social media support groups, the researcher realized there was a problem. No frame of reference was available to the researcher to compare their experiences with others' experiences with PM. Close female family members never spoke of their experiences with PM or menopause in general. Many family members had to have hysterectomies and either did not have severe symptoms or social norms dictated that "you do not talk about such things." Information disseminated is conflicting, inaccurate, confusing, and expensive, leaving women frustrated, dismissed, alienated, and wondering where to go next. Through research and informal discussions with others about their experiences, the researcher concluded that there has to be a better way to handle this stage in a woman's life so that no woman is alone.

Problem Statement

There is a wealth of information published concerning the stages of menopause from medical, personal, self-help, and mental health perspectives; however, much of the information available for women in this stage of life is inconsistent (i.e., stages of MP, length of time, ages). Much of the information concerns medications (e.g., antidepressant anxiolytic, estrogen, hormones) rather than other forms of treatment (e.g., natural, homeopathic, holistic, counseling). Due to the inconsistencies in information provided concerning the stages of menopause, many women are left frustrated with how they can best help themselves through this stage.

One of the issues is a lack of consistency in menopause education in most American obstetrics and gynecology training programs; therefore, no standardized level of care exists to equip residents with the tools they need to provide adequate care to menopausal women (The

Menopause Society, 2023). A needs assessment survey conducted in 2013 concerning menopause education in medical residency programs revealed that there is a lack of dedicated education on the topic of menopause (Allen et al., 2023; Christianson et al., 2013; Krewson, 2023; The Menopause Society, 2023; Naidorf, 2023; Open Access Government, 2023). At the time of the survey, which was the last needs assessment conducted for menopause education, only 20.8% of residents reported their program had a dedicated curriculum on the topic of menopause, while only 16.3% reported participation in a clinic specifically for menopause (Allen et al., 2023; Christianson et al., 2013; The Menopause Society, 2023). Most medical school residents of all levels have expressed that their knowledge of menopause education (i.e., pathophysiology of symptoms, hormone therapy, nonhormone therapy, bone health, cardiovascular disease, metabolic syndrome) is limited (Christianson et al., 2013). Menopause education consists of lectures (five or fewer per year) and assigned readings, or menopause education was regulated to a rotation block (Krewson, 2023; The Menopause Society, 2023). The majority of residents surveyed (83.8%) stated that more resources were needed on menopause education, such as supervised clinics, case presentations, formal lectures, small groups, web-based learning, and independent or self-paced study (Allen et al., 2023; Christianson et al., 2013; Krewson, 2023; The Menopause Society, 2023).

There is also little research concerning women's mental health and lived experiences during midlife, particularly during the years of PM. Much of the literature on PM concerns quantitative measures; however, the lived experiences of PM Christian women are almost non-existent. But PM is a global health issue that needs to be discussed and normalized (Hunt, 2016; Muharam et al., 2018; Onder & Batigun, 2016; Sandilyan & Dening, 2011; Sharma & Mahajan, 2015). Medical and psychological side effects of PM include insomnia, menstrual irregularities,

night sweats, hot flushes, decreases in libido, metabolic changes, headaches, weight gain, emotional instability, mood swings, depression, anxiety, and memory problems (Delamater & Santoro, 2018; Elavsky, & McAuley, 2007; Gibbs et al., 2013; Mauas et al., 2014; Pagán, 2018; Sandilyan & Dening, 2011; Terauchi et al., 2013). Additionally, many women experience lack of social support due to isolation, shame, guilt because they are unable to have children, marital discord due to lack of sexual desire for their partner, and other negative social and religious/spiritual (R/S) factors associated to PM (Bromberger & Epperson, 2018; de Kruif et al., 2016; Gibbs et al., 2013; Grochans et al., 2018; Jagtap et al., 2016; Muslić & Jokić-Begić, 2016; Pimenta et al., 2014; Steffen, 2011).

Further, in the past women were not encouraged to talk about menopause. When it was discussed, the discussions were referred to as "going through the change." Females of Generation X (GenX), born from 1965 to 1980, are entering PM or are currently PM or postmenopausal (i.e., age range 43-58 years). Popular culture for GenX females growing up in the 1970s and 1980s portrayed menopause as something to "dread" or fear, and female characters were portrayed as feeling "less than a woman" due to their inability to reproduce (Harper et al., 2022; see also Finestra et al., 1999; Hanalis et al., 1981; Harris & Hughes, 1986; Lear et al., 1972; Turner et al., 2002). Nevertheless, in more recent years, PM and menopause have been more positively embraced in popular culture as something to be discussed, celebrated, complained about with girlfriends, and normalized as an undeniable part of women's lives (see Cox, 2022; Fadal, 2023; Kapital Entertainment, 2022; King, 2010).

Despite efforts to bring women's physical and mental health to the forefront, according to feminist theorists, the dismissal of women's health concerns is due to the residual patriarchal control of the medical field (Enns, 2004; Hennessy, 2014; Kantola, 2016; Weedon, 2003). Many

women who seek treatment for their PM symptoms report that they are given false or disingenuous information or that their concerns are dismissed, leaving them disappointed and discouraged. To better understand and effectively treat the mental health needs of PM Christian women, this study focused on personal identity before and after the commencement of symptoms, symptom identification, and positive and negative coping strategies. The findings of this study can provide insight and clarification to this global health issue and provide needed information to medical and mental health care providers to successfully support PM women to have more affirmative outcomes in their physical, emotional, social, and spiritual lives during PM.

Purpose of the Study

This phenomenological qualitative study aimed to explore the lived experiences of PM Christian women from a bio-psycho-social-spiritual perspective through the lens of feminist theory. Data were collected from 10 participants who identified as PM Christian women (i.e., medical diagnosis of PM by non-surgical means, Christian faith, assigned female at birth, over 35 years old). Identifying the lived experiences of PM Christian women was chosen as the focus of this study due to the lack of current research on this specific population of women. PM status was identified by medical diagnosis or symptom identification as indicated in the initial screening questionnaire. Lived experiences were defined as the daily life experiences associated with PM as described by the study participants in response to the semistructured interview with the researcher. Approaching this research from a bio-psycho-social-spiritual and feminist theory framework enabled the researcher to gain a more holistic understanding of the participants' lived experiences of their physical health, mental health, and spiritual well-being while also highlighting obstacles women have traditionally faced to acquire proper healthcare and bring

awareness of the unique needs of PM Christian women (Braidotti, 2003; Disch & Hawkesworth, 2016; Engel, 1997; Koenig, 2012; Leavy & Harris, 2019; McCann & Kim, 2017; Porter, 2020; Saad et al., 2017; Zerilli, 2016). The expectation is that the themes derived from the semistructured interviews will provide needed understanding, awareness, and compassion for those in support roles (e.g., medical and mental health professionals, friends, and family members) for these women.

Significance of the Study

This study fills a gap in the current research about the lived experiences of PM Christian women. Many studies have focused on PM; however, most, if not all of these studies used quantitative methods to investigate PM symptoms or treatment outcomes and fewer incorporated R/S factors (see Baquedano et al., 2023; Naworska et al., 2020; Shokri-Ghadikolaei et al., 2022; Włodarczyk & Dolińska-Zygmunt, 2019; Woods & Mitchell, 2016). Quantitative studies focused on PM are essential; however, the voices of PM Christian women need to be heard. Research devoted to the lived experiences of PM Christian women's mental, emotional, and spiritual health is lacking or outdated, and research and advocacy are needed. Participants' experiences (i.e., perceptions, challenges, relationships with family and friends, social supports, resources, spirituality, coping mechanisms) during PM were identified and discussed to provide a deeper understanding of this phenomenon. The purpose of gathering these stories is to offer practical resources for PM Christian women to have open discussions about their symptoms with their support systems (i.e., friends, family, medical professionals, mental health professionals) and offer ways the mental health profession can provide appropriate care to PM Christian women.

In general, PM women are likely to experience mental, emotional, and cognitive (e.g., depression, anxiety, mood instability, forgetfulness, hostility) issues during PM more than other

phases of menopause, with depression being the primary complaint (Becker et al., 2007; Blackmore et al., 2008; Bromberger & Epperson, 2018; Bromberger et al., 2007, 2011; Delamater & Santoro, 2018; Flores-Ramos et al., 2018; Gibbs et al., 2013; Jagtap et al., 2016; Karkhanis & Mathur, 2016). But few studies have addressed how PM has affected Christian women's R/S experience (e.g., increase or interruption in R/S practices or attendance at R/S services or events; closer relationship with God; feelings of guilt, shame, stigma from the R/S community). For PM Christian women whose identity is significantly tied to motherhood and family, these women are more likely to feel guilt and shame from their R/S communities due to their inability to have children (Steffen, 2011). Conversely, R/S does play a positive role in decreasing menopausal symptoms by allowing women to feel a sense of peace, meaning in life, compassion, and forgiveness of self and others (Steffen, 2011). Spiritual coping skills (e.g., prayer, pastoral counseling, service attendance, and spiritual relationship with God) assist them in finding meaning amid their physical, mental, and emotional struggles (Milner et al., 2020). Additionally, symptom development and intensity of the physical illness are reduced for those who relied on their faith (Pimenta et al., 2014; Steffen, 2011). If PM symptoms are unchecked, long-term wellness and quality of life may suffer (Shokri-Ghadikolaei et al., 2022). R/S is fundamental to a client's worldview (i.e., how the client views the world, right and wrong, good and bad) and must be surveyed in the intake, assessment, and treatment process (Paterson & Francis, 2017).

The significance of this research is to provide needed insight for those who have not or will not experience PM (e.g., females who have not entered this life phase yet or males) as a Christian woman but who may work or interact with this population. As mentioned, PM is a global health issue with millions of women affected (Hunt, 2016; Sharma & Mahajan, 2015).

The ripple effect of PM encompasses millions more people (e.g., family, friends, medical and mental health professionals) who are more indirectly affected by the symptoms of PM. Participants shared their challenges, hardships, frustrations, joys, accomplishments, triggers, and perspectives on coping through PM as a Christian woman.

Empirically

This study contributed to the body of knowledge to empower PM Christian women to get the support that is needed. Many women lack the education, support, or understanding of their PM symptoms and lack support from friends, family, and medical professionals (Grose, 2021; Harper et al., 2022; Losinski et al., 2021; National Institute on Aging, 2022). Additionally, there are inconsistencies in the published information provided for menopausal women, leaving women frustrated and confused about how they can best alleviate their symptoms. Medical school residency programs do not provide sufficient education on menopause, as evidenced by a needs assessment that was conducted in 2013 (the last known reported survey of this type) to identify the needs of obstetric and gynecological residents (Allen et al., 2023; Christianson et al., 2013; Krewson, 2023; The Menopause Society, 2023). By 2025, it is estimated that over 1 billion women will have directly experienced PM globally. Normalizing the discussion of menopause and recognizing that it is a natural biological process is critical to destigmatization.

Further, related research focuses on the physical, pharmaceutical, mental, emotional, and psychological symptoms associated with PM, mainly from a quantitative perspective (see Bromberger & Epperson, 2018; Bromberger et al., 2001; de Kruif et al., 2016; Delamater & Santoro, 2018; Flores-Ramos et al., 2018; Gibbs et al., 2013; Gordon-Elliott et al., 2017; Grochans et al., 2018; Hunt, 2016; Jafari et al., 2014; Mauas et al., 2014; Muslić & Jokić-Begić, 2016; Onder & Batigun, 2016; Sandilyan & Dening, 2011; Terauchi et al., 2013). These studies

are excellent sources of information; however, they do not address R/S factors concerning the biological, psychological, social, and spiritual health of PM Christian women. Other related literature addresses mental health and R/S but does not look at how these factors affect PM Christian women (see Abdel-Khalek, 2012; Aldwin et al., 2014; Brandt et al., 2009; Dilmaghani, 2018; Johnson et al., 2022; Knabb, 2012; Koenig, 2012; Krause et al., 2016; Maltby et al., 2010; Mohr, 2011; Oxhandler et al., 2018; Pargament & Lomax, 2013; Paterson & Francis, 2017; Pearce & Koenig, 2013; Peres et al., 2018; Propst, 1988; Ramírez Stege & Godinez, 2022; Rosmarin et al., 2009; Snider & McPhedran, 2014; Steffen et al., 2017; Tulbure et al., 2018; Walker et al., 2011). Few studies found investigated any stage of menopause and R/S (Modarres & Aghaei, 2021; Pimenta et al., 2014; Steffen, 2011). This phenomenological qualitative study contributed to the literature, specifically to the lived experiences of PM Christian women. Their experiences are explored from a bio-psycho-social-spiritual perspective, focused on self-identity and positive and negative coping strategies with the goal of how mental health professionals, support systems, and medical professionals can work with, for, and for better care of PM Christian women.

Theoretically

This study contributed conceptually and theoretically to the bio-psycho-social model with spirituality as an added component and feminist theory to reveal the interconnection of the physical, mental, emotional, cognitive, relational, and spiritual aspects of an individual and to bring awareness to the needs of PM Christian women and challenge, eliminate, or change previously held attitudes about PM women's mental health (Arinder, 2020; Bell et al., 2018; Engel, 1997; Hawkesworth & Disch, 2016; Koenig, 2012; Personal Narratives Group, 1989; Porter, 2020; Saad et al., 2017). Physical, mental, and emotional symptoms and the interrelation

of these symptoms of PM have been documented in the literature. Nevertheless, these symptoms have not been studied sufficiently for PM Christian women and their needs. This study yielded comparable findings to the related literature, in addition to discoveries concerning the physical, mental, emotional, social, and spiritual lived experiences of PM women from a phenomenological perspective. Furthermore, this study revealed new ways PM Christian women are supported.

Practically

The intention of this study is to give voice to a population that is rarely heard concerning their lived experiences as PM Christian women. There are several possible reasons for their exclusion from the research literature despite the growing number of women who experience PM worldwide (see Allen et al., 2023; Christianson et al., 2013; Ehlers, 2016; Enns, 2004; Hennessy, 2014; Kantola, 2016; Krewson, 2023; The Menopause Society, 2023; Naidorf, 2023; Nicholson 2010/2017; Open Access Government, 2023; Weedon, 2003). This study can offer hope for other PM Christian women who are affected by the physical and psychological symptoms of PM in their social and spiritual lives and empower women to seek out the resources they need to obtain better care. Additionally, this study provides insight to those working with PM Christian women, such as family, friends, mental health, and medical professionals, on how to support their needs and understand how PM can affect their physical and psychological health. Lastly, this study can help destigmatize the conversation of menopause, empowering women to talk to their physicians and counselors as well as each other and the next generation of women to help prepare them for this stage of life better. This study can expand awareness, thoughtfulness, and positive outcomes to a natural biological process in women that has left many women stigmatized, ignored, brushed off, misdiagnosed, misinformed, anxious, depressed, untreated, isolated, and ashamed because

they do not understand what they are going through or how to improve.

Research Questions

Qualitative phenomenological inquiry is only about lived experiences, and research questions (RQs) are used to explore, understand, and discover the lived experiences of participants (Flamez et al., 2017; Peoples, 2021). RQs offer detail and transparency to support what the researcher investigated but do not assume the presence of a problem that has not already been identified in the literature. The questions posed allowed participants to express their thoughts, feelings, and experiences of the phenomenon without restriction or guidance from the researcher (Flamez et al., 2017; Peoples, 2021). In the current study, the RQs helped uncover the physical, psychological, mental, emotional, relational, and spiritual descriptions of PM Christian women in addition to the identification of their coping strategies and brought awareness and understanding to this often-misunderstood phenomenon.

Central RQ

The lived experiences of PM Christian women became of interest to the researcher due to their own experience as a PM Christian woman, in addition to learning of similar experiences from colleagues, acquaintances, friends, and family members, and the lack of satisfactory research on the subject that has led many women with frustration on their physical and mental health. To elicit this information, the central RQ asks: “How would PM Christian women describe their physical, psychological, mental, emotional, relational, and R/S lived experiences?” The most significant physiological changes impacting physical and mental functioning occur during PM (Delamater & Santoro, 2018; Gibbs et al., 2013). For PM Christian women, especially for those whose self-identity is tied to family, the inability to bear children may result in guilt and shame (Steffen, 2011). Nevertheless, menopausal symptoms have declined for R/S

women as they reported a sense of peace, life purpose, and forgiveness of self and others (Steffen, 2011).

Additional RQs

The following RQs were developed to gain a better understanding of PM Christian women's perspectives on their physical, psychological, social, and spiritual experiences:

RQ 1: How do participants describe their physical health during PM?

RQ 2: How do participants describe their mental health during PM?

RQ 3: What were the social/sexual experiences of PM Christian women?

RQ 4: What did PM Christian women experience in their R/S life?

Definition of Terms

The following definitions were used to provide clarity for the terminology used in this study.

Menopausal processes (MP): For this study, MPs are the individual stages of the overall menopausal experience (pre-, peri-, post-menopause).

Menopausal transition (MT)/PM: Typically beginning in a woman's early to mid-30s, PM is described as the beginning of the nonreproductive phase of a woman's life. Lasting 10 or more years, most of the physiological changes that will significantly impact biological and psychological functioning will occur (Delamater & Santoro, 2018; Elavsky & McAuley, 2007; Gibbs et al., 2013; Gordon-Elliott et al., 2017; Mauas et al., 2014; The North American Menopause Society, 2023; Sandilyan & Dening, 2011). PM concludes at menopause (i.e., 1 year and 1 day following the last menstrual cycle; The North American Menopause Society, 2023)

Postmenopause: The time after 1 year and 1 day following the last menstrual cycle. Due to longer life expectancies, many women will experience up to a third of their lives in postmenopause (Carcelén-Fraile et al., 2020; Hunt, 2016; Sharma & Mahajan, 2015).

Premenopause: Not to be used interchangeably with PM, pre-menopause begins with the first menstrual cycle and includes what is known as the "childbearing years" (Bromberger et al., 2001, 2007; Freeman et al., 2004; The North American Menopause Society, 2023; Tangen & Mykletun, 2008; Treloar, 1981).

Summary

The chapter presented an introduction to MP, and PM in particular, and has discussed some of the challenges experienced by PM Christian women. MP was discussed briefly to give the reader an understanding and context of where PM fits into the life cycle. Additionally highlighted in this chapter was the significance of the physical and psychological changes women experienced during this phase of MP (Delamater & Santoro, 2018; Gibbs et al., 2013). The purpose of this research was to explore the lived experiences of PM Christian women from a bio-psycho-social-spiritual perspective through the lens of feminist theory. Then this chapter presented the problem statement, RQs posed, and definition of essential terms. Lastly, this chapter discussed the study's empirical, theoretical, and practical significance.

CHAPTER TWO: REVIEW OF THE LITERATURE

Overview

The literature review illuminates the prevailing research concerning the focus of the study, beginning with the theoretical orientation. This review offers a general impression of menopause. The focus shifts to a bio-psycho-social-spiritual approach regarding the specific phases of menopause, followed by effective treatments found in the literature. Finally, the researcher will identify and discuss the gap in the literature, along with the need for future research. The purpose of this literature review is to lay the groundwork for the study by recounting previous research conducted concerning the effect of mental health counseling and protective factors, specifically spirituality, self-care, and social support, on treating the physical, psychological, and social symptoms of the MT. The literature review also highlights a gap in the literature and supports the need for additional exploration of Christian women's lived experiences during the MT, which was addressed in this study.

Related Literature

Menopause is a natural biological process and a significant life event affecting millions of women worldwide, signaling the end of fertility (Grochans et al., 2018; Kopciuch et al., 2017; Muslić & Jokić-Begić, 2016; Onder & Batigun, 2016; Sandilyan & Dening, 2011; Sharma & Mahajan, 2015; Steffen, 2011). Three stages occur during menopause (pre-, peri-, and postmenopause), which can begin as early as the early-30s and last through the mid-to-late 60s, resulting in biological, social, and psychological changes (Muharam et al., 2018; Onder & Batigun, 2016; Sandilyan & Dening, 2011; Sharma & Mahajan, 2015). Due to its global impact, menopause has become a significant public health concern globally for women (Hunt, 2016; Sharma & Mahajan, 2015). Women have a longer life expectancy (average 84 years), resulting in

the possibility of a woman spending a third of her life in postmenopause. The physical, social, and psychological changes of menopause bring about various symptoms that, if unmonitored, lead to decreased quality of life (Frey et al., 2013; Sandilyan & Dening, 2011; Sharma & Mahajan, 2015). For example, physical symptoms could include hot flashes, heart irregularities, sleep disturbances, muscle, and joint pain and discomfort, feeling exhausted or rundown, sexual problems, and urinary inconsistencies. Psychological symptoms that may occur during menopause include depressed mood, low energy, irritability, anxiety, and mental exhaustion. Social issues that can arise during PM include withdrawal, avoidance, and the effects of changes in social circumstances such as marital separation, divorce, work, and parenting stressors, or caring for aging parents (Frey et al., 2013; Sandilyan & Dening, 2011; Sharma & Mahajan, 2015). “Quality of life” is commonly described as a balance of biological, psychological, social, and spiritual functioning, as each concept makes up the whole person (Jafary et al., 2011). Therefore, “quality of life” must be acknowledged as it is very subjective from one person to the next, influenced by individual beliefs, perceptions, health status, culture, and education, among other factors.

There is a great deal of literature focused on the physical aspects (e.g., sleep difficulties, hormonal fluctuations, weight gain, hot flushes, night sweats) and pharmaceutical treatments of menopause (e.g., estradiol, estrogen; oral contraceptives; hormone replacement therapies; Bromberger & Epperson, 2018; Bromberger et al., 2001; Delamater & Santoro, 2018; Gordon-Elliott et al., 2017; Hunt, 2016; Onder & Batigun, 2016; Terauchi et al., 2013). Additionally, there is an abundance of literature dedicated to mental health conditions related to menopause (e.g., depressed or anxious mood, low energy, irritability, mental exhaustion; Bromberger & Epperson, 2018; de Kruif et al., 2016; Delamater & Santoro, 2018; Flores-Ramos et al., 2018;

Gibbs et al., 2013; Grochans et al., 2018; Jafari et al., 2014; Mauas et al., 2014; Muslić & Jokić-Begić, 2016; Onder & Batigun, 2016; Sandilyan & Dening, 2011). But research on protective factors, such as spirituality, self-care, and social support during menopause, along with women's lived experiences, was a bit more challenging to acquire. The proceeding sections will concentrate on the related literature on the phases and common symptoms women experience from a physical, mental, social, and spiritual perspective.

Stages and Common Symptoms Experienced from a Bio-Psycho-Social-Spiritual Perspective

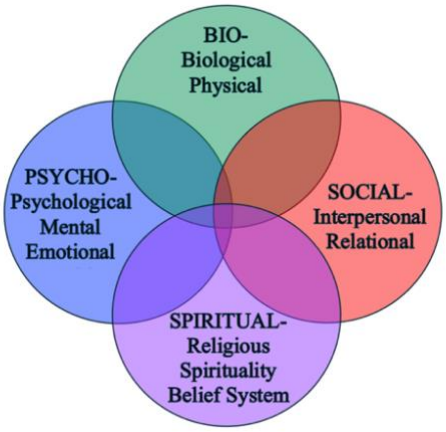
The bio-psycho-social model offers a conceptual framework for approaching what clients reveal about their experiences within their physical and mental health, which are frequently connected, adding the human element to the scientific domain and allowing for a more holistic approach to treating clients/patients (Engel, 1997; Porter, 2020; Saad et al., 2017). Despite being a fluid concept, incorporating "spirituality" or "religiosity" into the bio-psycho-social model enables the clinician to obtain a richer understanding of the client, as many clients lean on their R/S beliefs as a means of coping. For the clinician, the incorporation of R/S beliefs transforms approaches to diagnosis and treatment, ultimately leading to an increased quality of life (Koenig, 2012; Saad et al., 2017).

Spirituality has different meanings for different people based on multiple factors. Spirituality provides interconnectedness, meaning and purpose, wellness, an increased sense of self and improved self-esteem, coping skills to relieve feelings of depression and anxiety, and give a sense of hope (Briggs & Dixon, 2013; Mohr, 2011; Yonker et al., 2012). Religion carries a more negative connotation in the literature, particularly concerning women (e.g., man is seen as master by divine right, female repression, doctrinal, institutionalized, ritualistic, authoritarian;

Briggs & Dixon, 2013; Koenig, 2012; Yonker et al., 2012; see also de Beauvoir, 1953/2021; Irigaray, 1993). Though quality of life can be defined as the appropriate functioning of biological, psychological, social, and spiritual domains that make up the whole person (Jafary et al., 2011), subjective concepts such as individual beliefs, perceptions, health, culture, education, among other factors, cannot be ignored. In the following sections, each stage of menopause (pre-, peri-, postmenopause) are reviewed using the bio-psycho-social-spiritual framework. Figure 1 is a representation of the bio-psycho-social-spiritual model and how each aspect of the model is interconnected to the next part to make up the whole person.

Figure 1

Bio-Psycho-Social-Spiritual Model



Premenopause

Frequently in the literature, premenopause and PM are used interchangeably; however, these two stages of menopause have different meanings and carry a unique set of symptomatology (Onder & Batigun, 2016). Also of note, the term “premenopause” is not an accepted clinical term (Nall, 2021). The premenopausal stage begins with the first menstrual cycle and encompasses what is known as the “childbearing years” of a woman’s life (Bromberger et al., 2001, 2007; Freeman et al., 2004; Tangen & Mykletun, 2008; Treloar, 1981).

The following sections will provide an overview of the bio-psycho-social-spiritual factors regarding the premenopausal stage of menopause.

Biological. The premenopausal stage of menopause, referred to as a woman's reproductive or fertile years, is the beginning of a female's menstrual cycle (age at first menstrual cycle varies from person to person) and is accompanied by regular bleeding patterns monthly (Bromberger et al., 2001, 2007; Freeman et al., 2004; Tangen & Mykletun, 2008; Treloar, 1981). Identified symptoms of premenopause include abdominal cramping, heavy menstrual bleeding, mood swings, anxiety, headache, fatigue, back pain, nausea and vomiting, depression, breast tenderness, and irritability, as well as other symptoms associated with PMS (Freeman, 2003; Gollenberg et al., 2010; Schoep et al., 2019). Other common conditions during premenopause include poly cystic ovarian syndrome (PCOS) and premenstrual dysphoric disorder (PMDD). PCOS is an endocrine disorder characterized by menstrual irregularity, pregnancy issues (infertility, miscarriage, premature delivery, pregnancy-induced hypertension or gestational diabetes), hyperandrogenemia (i.e., high levels of androgens in women, which may be accompanied by acne, seborrhea, hair loss, increased body or facial hair, menstrual irregularities), oligovulation (irregular ovulation), obesity, and polycystic ovaries (Gordon-Elliott et al., 2017). PMDD is a severe form of PMS with symptoms such as bloating, mood swings, lethargy, irritability, breast tenderness, anxiety or tension, weight gain, and rejection sensitivity.

Psychological. Common psychological factors experienced during premenopause include psychiatric disorders such as depression (e.g., major depressive disorder or major depressive episodes) and anxiety (Manikandan et al., 2016; Toffol et al., 2014; Yu et al., 2017). According to the research, hormonal fluctuations appear to be the primary cause of menstrual-related mental health disorders (Chen et al., 2016; Talukdar et al., 2019; Tangen & Mykleton, 2008; Toffol et

al., 2014; Yu et al., 2017). Additionally, many females during this phase experience difficulty with emotion regulation, mood swings, irritability, crying spells, increased stress, and feeling out of control (Freeman, 2003; Gollenberg et al., 2010; Manikandan et al., 2016; Schoep et al., 2019; Toffol et al., 2014; Yu et al., 2017). Conditions such as PCOS bring another level of mental health and psychological distress in the form of hirsutism (excessive facial hair) and obesity, which may affect body image (Gordon-Elliott et al., 2017). Menstrual dysfunction and fertility issues can also affect female identity and cause relationship disruption. Depression and anxiety are associated with PCOS, decreased quality of life, and disordered eating (binge eating; Gordon-Elliot et al., 2017). Common psychological symptoms of PMDD include mood swings, irritability, and anxiety or tension. PMDD appears more prevalent for those with depressive and anxiety disorders and substance use disorders (Gordon-Elliott et al., 2017).

Social. Social effects of dysmenorrhea (painful periods) are widespread and the primary reason for women's absences from work and school during this stage (Chen et al., 2016). In a study on 42,879 women, dysmenorrhea accounted for 7.7% to 57.8% of adolescent females missing school or exhibiting decreased performance, and 40% of women reported being significantly affected in their daily activities result of menstrual symptoms (Schoep et al., 2019). These activities included caring for children or elderly parents, work, or other social activities. For those with PCOS, common social challenges include negative body image (e.g., excessive facial hair, acne, alopecia, obesity) and emotional distress and relationship difficulties (Gordon-Elliott et al., 2017). Additionally, challenges experienced with fertility can affect a woman's identity, how she sees herself as a woman, and how others see her as a woman, wife, or partner, which leads to emotional distress and relationship difficulties (Gordon-Elliott et al., 2017). Socially, PCOS and PMDD significantly impact daily life (e.g., decreased productivity, missing

work or school, and negative social interactions; Schoep et al., 2019).

Spiritual. The literature does not explicitly cover spirituality during the premenopause phase of menopause; however, it has been shown that female adolescents and young adults identify as R/S more than male adolescents (Benson et al., 2005; Büssing et al., 2010; King & Roeser, 2009; Livingston & Cummings, 2009). Spirituality for women provides a "connectedness" to others, a Higher Power, and the Universe. Religious and experiential coping has been shown to encourage, guide, reassure, make meaning, and give women a sense of well-being (Livingston & Cummings, 2009). Additionally, women engage in "solitary spiritual activities" that are private or seen as nontraditional such as meditation, prayer, nature, and listening to music, thus improving mental health (Koenig, 2010; Livingston & Cummings, 2009).

PM

The PM stage, or MT, is the next in the MP. PM can begin as early as a woman's early 30s and last 10 or more years, beginning the non-reproductive phase of a woman's life (Delamater & Santoro, 2018; Elavsky & McAuley, 2007; Gordon-Elliott et al., 2017; Mauas et al., 2014; Sandilyan & Dening, 2011). During this phase of menopause, women will experience the most physiological changes that will significantly influence their biological and psychological functioning (Delamater & Santoro, 2018; Gibbs et al., 2013). The following sections will overview the bio-psycho-social-spiritual factors regarding the PM stage.

Biological. During the PM stage of menopause, hormone (i.e., estrogen, progesterone, testosterone) levels decrease and vary widely, resulting in irregular menstrual cycles and physical and mental health symptoms, leading to the nonreproductive stage of a woman's life (Bromberger et al., 2001; Delamater & Santoro, 2018; Elavsky, & McAuley, 2007; Gordon-Elliot et al., 2017; Mauas et al., 2014; Sandilyan & Dening, 2011; Treloar, 1981). The PM phase,

lasting anywhere from a few years to 10 years or more, commonly begins as early as a woman's early 30s. Common physical health symptoms experienced during this stage of menopause include insomnia, irregular menstrual cycles, night sweats, hot flushes, sexual dysfunction, metabolic irregularities, headaches, weight gain, and random aches and pains, which have been shown to negatively affect a woman's quality of life, relationships, and occupational life (Delamater & Santoro, 2018; Elavsky, & McAuley, 2007; Frey et al., 2013; Gibbs et al., 2013; Hunt, 2016; Levin, 2015; Mauas et al., 2014; Pagán, 2018; Sandilyan & Dening, 2011; Terauchi et al., 2013; Woods & Mitchell, 2011; Worsley et al., 2014).

Psychological. Due to instabilities in hormone levels, some women experience various mood changes and experience mental health issues (Delamater & Santoro, 2018; Elavsky & McAuley, 2007; Gibbs et al., 2013; Hunt, 2016; Levin, 2015; Mauas et al., 2014; Pagán, 2018; Pearson, 2010; Sandilyan & Dening, 2011; Terauchi et al., 2013; Woods & Mitchell, 2011; Worsley et al., 2014). Common mental health issues associated with PM include emotional instability, irregular mood, depression, anxiety, cognitive deficits, forgetfulness, hostility, and confusion. For some women, there is an increased risk for reoccurrence of, or initial onset of, major depression (Becker et al., 2007; Blackmore et al., 2008; Bromberger & Epperson, 2018; Bromberger et al., 2007; Delamater & Santoro, 2018; Gibbs et al., 2013). Studies have shown during PM, women are at much greater risk for developing depression and anxiety compared to other stages and phases of their lives, with depression being the primary complaint (Becker et al., 2007; Bromberger & Epperson, 2018; Bromberger et al., 2011; Flores-Ramos et al., 2018; Jagtap et al., 2016; Karkhanis & Mathur, 2016). Additionally, some women who experienced postpartum psychosis are at greater risk of experiencing bipolar episodes during PM due to hormonal changes (Blackmore et al., 2008). Universal depression screenings are important in

primary care settings for women in midlife as some women are at increased risk of initial onset or recurrence of mental health disorders (e.g., depression, bipolar disorder, schizophrenia) that were previously managed (Leistikow & Smith, 2022).

Social. Beyond the hormonal inconsistencies that lead to physical and emotional difficulties, social issues also occur and impact women in this age group and stage of menopause. Social factors that affect PM women include dysfunctional familial, friend, or intimate partner relationships, employment status or financial issues, lower level of education, perceived health condition or health issues, and adverse life events (Bromberger & Epperson, 2018; de Kruif et al., 2016; Gibbs et al., 2013; Grochans et al., 2018; Jagtap et al., 2016; Muslić & Jokić-Begić, 2016; Pimenta et al., 2014). Additionally, these women have other duties, such as caring for small children or adolescents still in the home and aging parents (Bromberger & Epperson, 2018).

Spiritual. As previously mentioned, during PM, hormone levels change, leading to the nonreproductive phase of a woman's life (Bromberger et al., 2001; Delamater & Santoro, 2018; Elavsky & McAuley, 2007; Gordon-Elliot et al., 2017; Mauas et al., 2014; Sandilyan & Dening, 2011; Treloar, 1981). For some women whose identity is significantly tied to family, the loss of their ability to bear children is profoundly impacted during PM (Steffen, 2011). However, R/S does play a positive role in decreasing menopausal symptoms by allowing women to feel a sense of peace, meaning in life, compassion, and forgiveness of self and others (Steffen, 2011).

Postmenopause

Biological. Postmenopause begins after 12 uninterrupted months of no menstrual cycles (Hunt, 2016). Due to longer life expectancy, postmenopause can take up a third of a woman's life, resulting in increased risk for osteoporosis, heart disease, and sexual dysfunction due to

diminished hormone levels (Carcelén-Fraile et al., 2020; Hunt, 2016; Sharma & Mahajan, 2015). Many symptoms women experience with the previous stages of menopause decline after a few years. However, cognitive degeneration and reduced physical functioning become health concerns, thus negatively affecting the quality of life (Anderson et al., 2014; Jafari et al., 2014).

Psychological. Common mental health concerns during postmenopause include depression and anxiety. But depression is the primary concern (Becker et al., 2007; Bromberger & Epperson, 2018; Bromberger et al., 2011; Flores-Ramos et al., 2018; Jafari et al., 2014; Jagtap et al., 2016; Karkhanis & Mathur, 2016). The psychological symptoms associated with menopause typically last through the first years of postmenopause (Kopciuch et al., 2017).

Social. As menopause is a global health concern, postmenopausal women are perceived differently from culture to culture (Jafari et al., 2014). For example, the loss of reproductive ability negatively influencing social status or marital relationships (Jafari et al., 2014; Steffen, 2011). In certain cultures, age holds a higher position, respect, and exceptional value and is considered prudent in making important decisions. (Jafari et al., 2014). Perceived health and stress levels influence postmenopausal women's work and social relationships (Woods & Mitchell, 2011). Symptom interference is the frequency and intensity of symptoms that negatively affect everyday life (e.g., hot flushes negatively affecting daily activities such as work, relationships, concentration, mood). From woman to woman, the type of symptom interference experienced will differ depending on the symptoms experienced (Jafari et al., 2014; Woods & Mitchell, 2011). Lower education, lack of a life partner, and unemployment are social factors that negatively contribute to adverse symptoms for postmenopausal women (Grochans et al., 2018). A woman's permanent residency (e.g., city or country) also plays into a postmenopausal woman's quality of life women residing in the city reported a higher quality of

life, whereas women living in the country reported lower quality of life (Jafari et al., 2014).

Spiritual. Despite the stigma some women experience during PM, as noted, R/S also decreases menopausal symptoms and allows women to feel a sense of peace, meaning in life, compassion, and forgiveness of self and others (Steffen, 2011). Peri- and postmenopausal women with higher levels of spirituality have identified lower levels of menopausal symptoms than nonspiritual women (Pimenta et al., 2014). Other researchers uncovered more heightened levels of resiliency in postmenopausal women as impacted by R/S involvement (Gold, 2015) as well as clinically significant outcomes of increased levels of spirituality in older women based on their level of social support and flexibility (Bailly et al., 2018). The following table outlines the bio-psycho-social-spiritual model of pre-, peri-, and post-menopause.

Table 1

Bio-Psycho-Social Model of Pre-, Peri-, and Post-Menopause Symptomatology

	Premenopause	Perimenopause	Postmenopaause
Biological	Abdominal cramping Heavy menstrual bleeding Headaches Fatigue Back pain Nausea Hormone fluctuations	Decreased hormonal levels Irregular menstrual cycles Insomnia Night sweats Hot flushes Sexual dysfunction Metabolic irregularities Headaches Weight gain Random aches and pains	One third of life Increased risk for osteoporosis and heart disease Reduced cognitive and physical function Decline of previous symptoms
Psychological	Depression Anxiety Emotional regulation Mood swings Irritability Crying spells Feeling out of control	Emotional instability Irregular mood Depression Anxiety Cognitive deficits Forgetfulness Hostility Confusion	Depression Anxiety Symptoms eventually decrease
Social	Frequent absences Decreased performance Negative body image Relationship difficulties Self-identity	Relationship difficulties Employment Financial issues Difficulties fulfilling commitments	Cultural perception Occupational relationships Social relationships Social factors Geography
Spiritual	Not specifically addressed Female adolescents identify of religious/spiritual Solitary spiritual activities	Self-identity Perception of others Positive role	Positive effect Resiliency Clinically significant outcomes

Cultural Considerations: Pre-, and PM

As mentioned, PM is a natural biological process, signaling the end of the childbearing years for women and cessation of the menstrual cycle, and is a significant global health issue that includes physical and psychological symptoms for many women (Delamater & Santoro, 2018; Elavsky & McAuley, 2007; Gordon-Elliott et al., 2017; Hunt, 2016; Kopciuch et al., 2017; Mauas et al., 2014; Onder & Batigun, 2016; Rindner et al., 2017; Sandilyan & Dening, 2011). Cultural considerations transcend geography, religion, ethnicity, and occupation, among other factors. Cultural values can change from one city to the next or one village to the next. How women are perceived during pre-, and PM has a major effect on mental health and overall well-being. The current study focused on PM Christian women predominately living in the United States, influenced by Western Christian culture. However, it is imperative to briefly mention the effects of PM on a woman's physical and mental well-being from a global perspective as PM is not exclusive to Western Christian culture.

Most religions, cultures, and societies worldwide have placed limitations on menstruating women (e.g., prohibitions on handling food, religious spaces, participation in public religious activities, engagement in public life; isolation; discrimination; sexual contact) that influence the perception (i.e., unclean, impure, shameful, diminished capacity) of women in society that lead to stigmatization (Ebeling, 2010; Gupta, 2022; Mazokopakis & Samonis, 2018; United Nations Fund for Population Activities [UNFPA], 2022). Menopausal women in communities that highly value large families such as small villages found in India, Iran, and Africa, fear possible abandonment from their husbands for younger women (Hall et al., 2007). That fear is compounded when total dependence (e.g., physical, financial, social) on the husband is concerned. Additionally, lack of knowledge (or conflicting information) concerning

menstruation and menopause, and patriarchal subjugation (e.g., India, Korea) of women in some cultures, have led to stigmatization (Gupta, 2022; Li et al., 2023; UNFPA, 2022). For example, Li et al. (2023) found in their study that Chinese menopausal women are often viewed as "abnormal people" and face discrimination and exclusion within the confines of their own homes. The UNFPA (2022) reported that in western Nepal, and similarly in parts of India, menstruating women are not allowed to cook food and are required to sleep outside of the home (i.e., in a hut or shed). Women's health is negatively affected by these stigmas concerning menstruation. Women are not allowed or not able to gain access to healthcare or given proper education or access on hygiene, which lead to more serious health risks. Furthermore, ethnic minority menopausal women in the United Kingdom (UK) experience many obstacles when it comes to healthcare due to language, self-consciousness or embarrassment, or simply the inability to express their health concerns in a coherent manner (MacLellan et al., 2023).

In the United States, and even the United Kingdom, conversations about PM are on the increase; however, there is still a level of stigma women experience particularly related to negative views on aging, loss of fertility, or sexual desire (Gupta, 2022). Due to this stigma, women are ill prepared for menopause, carry negative attitudes about menopause, and unable to effectively cope with this transition in their lives (Tariq et al., 2023). Conversely, positive cultural views on aging and menopause have been found to aid in a more optimistic environment for menopausal women in countries such as Sweden, Denmark, and Norway, thus allowing for an easier menopausal experience (Gupta, 2022). In communities where menopausal women gained social status, became healers, name givers, and were allowed to openly engage in religious practices due to restrictions being lifted as they are no longer menstruating monthly, more positive perceptions were expressed of menopause (Hall et a., 2007). In societies such as

the Tuareg, an Islamic tribe in Niger, menopausal women are elevated in status and engage in new social, ritual, and healing activities (Hall et al., 2007). Additionally, women in Rajasthan, India, who are prohibited from engaging in their regular daily activities during their menstrual cycles, reported they use the time away to visit family and are often happy to take a break (UNFPA, 2022). Cultures that regard older women with respect and honor, fewer negative menopausal symptoms or experiences are reported, which indicates the importance of how women view themselves and the role they play on their overall menopausal experience (Sergeant & Rizq, 2017). Lastly, women of various cultures expressed eagerness for menopause as they saw it as a time of freedom (Hall et al., 2007). Their families have been raised and they have more time to engage in different activities.

Religious Influence on Culture

Much has been stated in the Old Testament concerning attitudes toward or biblical metaphors regarding menstrual impurity, which has influenced the attitudes and beliefs espoused by Christianity (Cohen, 2020; Feinstein, 2021; Mazokopakis & Samonis, 2018; Meletiou & Meylahn, 2015; see *Amplified Bible*, 1965/2015, Gen. 18:11, Gen. 31:30-35, Lev. 15:19-24, Lev. 20:18, Isa. 30:22, Isa. 64:6, Lam. 1:9). In the Old Testament (i.e., Hebrew Bible, Pentateuch or Torah, Code of Legal Purity) under Mosaic Law (Lev. 11:1-15:33), a woman on her menstrual cycle is considered “unclean” and sexual relations are not permitted; furthermore, if sexual relations do occur, both the man and the woman are considered “unclean” until 7 days following the first day of menstruation, or both the man and the woman are cut off from their people (*Amplified Bible*, 1965/2015, Lev. 15:19-23, Lev. 20:18; Ebeling, 2010; Feinstein, 2021; Mazokopakis & Samonis, 2018). Mosaic Law deemed some bodily functions (i.e., menstruation) as detestable to God (Mazokopakis & Samonis, 2018). These biological functions of the body

were not sins as much as they were associated with the Jewish perception of sin (i.e., impurity or unholiness). According to Mosaic Law, purity and holiness were deeply intwined concepts. Furthermore, purity was a necessity for engagement in any worship activities as impurity was incongruent to the holiness of God (Mazokopakis & Samonis, 2018). Over time, the laws governing purity in Mosaic Law experienced changes. Directives pertaining to menstruation not only remained but became stricter than the guidelines presented in Leviticus 15, which are still observed by Orthodox Jewish people today and referred to the Laws of Niddah (Cohen, 2020). The Laws of Niddah forbid any physical contact between a married couple during menstruation and for seven "clean" or "white" days thereafter (Cohen, 2020; Neusner, 2010). Most liberal Jewish denominations today do not follow the Laws of Niddah, rather, they allow for personal choice in observance (Cohen, 2020).

The New Testament of the Holy Bible focused on the life, death, and resurrection of Jesus Christ. Jesus was not sent to eliminate the Mosaic Law but to justify the Law (*Amplified Bible*, 1965/2015, Mat. 5:17-18). Jesus called out the Pharisees for their misguided view of the Law. For example, more importance was placed on outward or external purity than internal purity or purification of the soul (*Amplified Bible*, 1965/2015, Mat. 5:20, Gal. 3:23; Mazokopakis & Samonis, 2018). Additionally, ritualistic traditions appeared more important to religious leaders of the time than spiritual worship and prophetic teaching (*Amplified Bible*, 1965/2015, Rom. 15:4; Mazokopakis & Samonis, 2018). Jesus did not conform to the Law, as it were, but was the Law. At this time, it was not common for unrelated men and women to converse in public; however, Jesus spoke directly and respectfully to women and included women as part of his ministry (*Amplified Bible*, 1965/2015, John 4:27, Luke 8:1-3, Luke 13:16; Meletiou & Meylahn, 2015). Those who were "unclean" were not banished by Jesus. For example, the

woman with the blood flow problem was not ostracized by Jesus; instead, she was healed because of her faith (*Amplified Bible,* 1965/2015, Luke 8:43-48). The Apostle Paul argued that the Mosaic Laws were man-made and held no value for those reborn in Christ (*Amplified Bible,* 1965/2015, Col. 2:20-23, 1 Tim. 1:8-11; Mazokopakis & Samonis, 2018).

Despite the voluminous accounts of the impurity of menstruation written in the Old Testament of the Bible, very little to nothing is mentioned about menopause. But Meletiou and Meylahn (2015) highlighted the transformation of Mary Magdalene following Jesus' death and resurrection. During a time where women were invisible in the eyes of their community, Jesus gave them a sense of self-worth and identity. Many PM women struggle with self-worth and a change in their identity during this time in their lives. Without Jesus, Mary and her other female companions that followed Jesus would disappear in the shadows of society, thus losing their identity and self-worth. This is real fear women have when faced with aging in western society (Meletiou & Meylahn, 2015). Mary's encounter with the risen Christ gave her the empowerment in her heart that she needed to minister His Word to all the nations (Amplified Bible, 1965/2015, Matt. 28:16-20, Acts 1:7-8). Mary Magdalene chose to follow Jesus Christ, which is where is found her identity. To this day, PM Christian women who struggle with the challenges of health, identity, and self-worth, choose to find their identity in Christ.

Effective Treatments Discussed in the Literature

As mentioned, PM women are more likely to experience psychological and emotional issues during menopause. Symptoms of depression, anxiety, and bipolar disorder may manifest, along with mood instability, cognitive deficits, forgetfulness, hostility, and confusion (Becker et al., 2007; Blackmore et al., 2008; Bromberger & Epperson, 2018; Bromberger et al., 2007; Delamater & Santoro, 2018; Gibbs et al., 2013). Studies have shown an increased risk of

continuous mental and emotional symptoms during PM more than during other phases of menopause (Becker et al., 2007; Bromberger & Epperson, 2018; Bromberger et al., 2011; Flores-Ramos et al., 2018; Jagtap et al., 2016; Karkhanis & Mathur, 2016). Symptoms of depression have been reported as the primary complaint. If symptoms go unchecked, long-term wellness and quality of life can suffer (Frey et al., 2013; Hunt, 2016; Jafari et al., 2014; Muharam et al., 2018; Onder & Batigun, 2016; Sandilyan & Dening, 2011; Sharma & Mahajan, 2015; Shokri-Ghadikolaei et al., 2022).

Medication

Management of symptoms is typically the general course of treatment. Under medication management, symptoms are reduced or eliminated through hormonal medications. However, despite the numerous benefits of hormone therapy, there is a possible risk of coronary heart disease and breast cancer, leading some women to opt for nonhormonal treatments (Meziou et al., 2023; Shokri-Ghadikolaei et al., 2022). Additionally, psychotropic medications in the form of antidepressants and/or anti-anxiolytics (e.g., sertraline, escitalopram, venlafaxine, fluoxetine, paroxetine) are recommended and prescribed to reduce mood swings and are also prescribed to treat vasomotor symptoms (e.g., hot flushes or night sweats) related to PM (Mayo Clinic Staff, 2023; Orleans et al., 2014). Nonpharmacological options are also available and have been shown to be effective as stand-alone treatments or to augment pharmacological treatments (e.g., health coaching, physical exercise, mindfulness/relaxation, mental health counseling, self-care; Lam et al., 2022; Shokri-Ghadikolaei et al., 2022).

Mental Health Interventions

Several theoretical orientations are available to counselors to treat depression, anxiety, bipolar disorder, and other mood disorders; however, cognitive behavioral therapy (CBT) has

been shown as the most effective treatment (Jennings et al., 2013). Drawn from the work of Aaron Beck (i.e., cognitive therapy) and Albert Ellis (i.e., rational emotive behavioral therapy), the focus of CBT is to identify, confront, and modify disruptive thoughts that challenge the emotions and behaviors of the client, and replace those thoughts with constructive, healthy behaviors (Beck, 1976; Jennings et al., 2013; Ellis, 1962; McMinn & Campbell, 2007; Pearce & Koenig, 2013). Research indicates the efficacy of spiritual interventions when integrated with secular theories such as CBT in treating mental health disorders (Hook et al., 2010; Jennings et al., 2013; Pearce & Koenig, 2013). Treatments that have been effectively adapted from CBT include mindfulness-based cognitive therapy (MBCBT), acceptance and commitment therapy (ACT), dialectical behavior therapy, and faith-integrated forms of CBT (e.g., Christian Accommodative CBT).

R/S in Mental Health Treatment. A client's worldview is just as important as the physical, mental, emotional, or social aspects of their lives. It should be addressed and integrated (with the client's consent) into the client's treatment plan for a more holistic, rather than a universalistic, approach to healing (Paterson & Francis, 2017; van Nieuw Amerongen-Meeuse et al., 2021). Inquiry into the client's symptoms is required to determine the next steps to augment treatment (e.g., referral to medical providers for hormone testing; Jagtap et al., 2016; Kanadys et al., 2016; Wariso et al., 2017). For millions of people, R/S identity forms and guides their core belief system, which influences how they interpret the world, cope, understand mental and physical illness, and themselves (Brandt et al., 2009; Milner et al., 2020; Oxhandler et al., 2018; van Nieuw Amerongen-Meeuse et al., 2021). R/S meets various human needs (e.g., meaning, purpose, comfort, self-confidence, connection with self or others; relationship with high power, transcendence, motivation, belonging; Culliford & Eagger, 2009; Mohr et al., 2006; Pargament

& Lomax, 2013; Ross et al., 2022; Swinton & Kettles, 2001). Appropriate assessment of a client's physical, behavioral, mental and emotional, social, substance use, and spiritual history, along with PM symptoms leads to greater mental and physical health outcomes. With R/S integrated in mental health treatment, patients have reported increased satisfaction with care, felt respected as a person, reported decreased symptoms of depression, a better quality of life, positive coping strategies, greater participation in treatment, and health outcomes (Beutel et al., 2009; Milner et al., 2020; Moreira-Almeida et al., 2014).

Examples of spiritually integrated secular theories include MBCBT, which has a basis in Buddhist meditation; however, MBCBT can be modified for use as a secular form of treatment or other spiritual use (i.e., Christian meditation; Knabb, 2012; Tan, 2011). MBCT is used to keep clients "in the moment" and focused on their bodily sensations throughout their individual experiences to separate themselves from negative thoughts, to prevent avoidance of the experience (Hathaway & Tan, 2009). Although not specifically spiritual, ACT is influenced by spiritual traditions such as mind and experience to comprehend and alleviate human suffering to acceptance (Hayes et al., 2012). Finally, dialectical behavior therapy, a method to help clients acknowledge their triggers that cause emotional reactivity to accomplish mental regulation, is adaptable for R/S use (Dimeff & Linehan, 2001; Liu et al., 2011).

Due to the immense changes (physically and mentally) that occur for some women during PM, it is necessary to mention the effect of existential-humanistic treatment in working with PM Christian women, particularly related to self-identity or sense of self (created from meanings made through lived experiences; Schneider & Krug, 2017). The focus of existential-humanistic (e.g., Frankl, Maslow, Rogers) therapy, according to May (1981), is to "set people free" (p. 18). In other words, the role of the counselor is to support their clients in gaining a

greater understanding of their choices within the natural (e.g., birth, heredity, age, death, separateness, uncertainty) and self-imposed (e.g., boundaries set by culture, language, lifestyle) limits of living (May, 1981; Schneider & Krug, 2017; Wong, 2006). Existential health psychologists work with patients in the medical setting who have experienced a significant life change or loss of self-identity (Whitehead, 2019). Existential health psychologists focus on the person of the human and the meanings they ascribe to life and all of its uncertainties. Patients' fears, skepticisms, doubts, and grief surrounding the significant life change are addressed. The search for the "new normal" or "new sense of self" is a deeply personal journey, especially for PM Christian women (Kogstad et al., 2011). Therefore, existential and spiritual needs must be addressed just as much as a patient's physiological needs to enjoy positive health and well-being (Koslander et al., 2009), and the integration of an existential philosophical approach is required in treatment.

Benefits of R/S in Mental Health Treatment. Numerous studies show the benefits of R/S integration of secular theories to treat mental health disorders. In a study to determine the beneficial value of religious or nonreligious CBT treatment groups, participants who engaged in R/S groups expressed decreased depressive symptoms, while participants in the nonreligious or waitlist groups did not report the same decrease in symptoms (Propst et al., 1992). Similar results were found in a study by Stanley et al. (2011), where participants expressed improved coping, problem-solving, and increased faith with the addition of R/S into their treatment. Further, in a study on 115 outpatients, results indicated that integration of R/S into the treatment of patients with psychotic illness was clinically significant, and R/S was found not to be specifically personal or cultural (Mohr et al., 2006). Comparably, in a study by Maltby et al. (2010), participants in the study reported better-quality physical and mental health. Additionally,

researchers have found meaningful associations between site and theoretical framework (i.e., client-centered, cognitive behavioral, solution-focused) and between site and spiritual interventions (i.e., acceptance of God's love, listening to the heart, forgiveness, in-session silent prayer; Johnson et al., 2022).

Despite these benefits, practical applications of R/S interventions for the treatment of depression, anxiety, bipolar disorder, and other mood irregularities during PM are lacking (Pimenta et al., 2014; Steffen, 2011). As with any form of therapy, cultural sensitivity is required when spiritual interventions are suggested to the client. Interventions such as prayer, scripture, prayer journals, spiritual-religious imagery or mystical practices, meditation, devotional readings, religious service attendance, and R/S study are integrated with secular therapies to decrease symptoms of depression and anxiety, which allows the client for spiritual growth and closeness with their higher power (Hook et al., 2010; Jennings et al., 2013; Knabb, 2012; Mohr, 2011; Steffen et al., 2017; Worthington et al., 2011). R/S imagery can be used as a visualization tool during stressful situations or to replace depressed or anxious negative thoughts (Propst, 1988). Additionally, inner healing prayer can be helpful for clients with unresolved trauma (Tan, 2007).

Theoretical Framework

Feminist Theory

Feminist theory is a political philosophy derived from "feminism," meaning political advocacy by women for women, which occurred alongside feminist activism and highlights obstacles that demarcate women's lives, provides insight into the dynamics and determination of women, and recognizes areas for change (Disch & Hawkesworth, 2016; McCann & Kim, 2017). The assumption behind feminist theories, "the personal is political," originated directly from the

disrespect feminists faced as a consequence of attempting to bring awareness and end gender discrimination in the 1960s (Braidotti, 2003; Leavy & Harris, 2019; Weedon, 2003; Zerilli, 2016). Feminist theory is considered political as a result of gender oppression. The discrimination women have encountered globally brings attention to popularized traditions that contribute to the marginalization of women (e.g., sex, race, sexuality, gender, identity, roles, duties, social position, spiritual authority, political rights, economic opportunities) in society (Disch & Hawkesworth, 2016; Leavy & Harris, 2019; McCann & Kim, 2017). Feminist theory began with the idea of exposing, challenging, and bringing to the forefront the physical, social, spiritual, political, civil, and financial subordination of women and calling on change of the prejudiced conditions women lived in (Disch & Hawkesworth, 2016; Hughes, 2002; Leavy & Harris, 2019; McCann & Kim, 2017).

Feminist theoretical frameworks seek to uncover and discontinue oppressive systems and structures that negatively affect any person or group (Arinder, 2020). Feminist theory challenges long-held dogmatic attitudes from academic disciplines such as the humanities, social and behavioral sciences, and natural sciences by providing new evidence, new ideas, and alternative ways to view the lived experience of women (Hawkesworth & Disch, 2016). Feminism and feminist theory intend to challenge traditionally (i.e., based on white male knowledge, truth, and reality as the norm) held beliefs and ideas about how society should work (Bell et al., 2018; Personal Narratives Group, 1989). The aim of feminism is the awareness, expansion, and transformation of the socially determined oppression of women and the desire to right the wrongs of gendered suppression and develop and replace current societal politics where both women and men experience self-sufficiency and autonomy (Worrell & Johnson, 1997). The use of feminist theory in practice seeks to produce solutions for discrimination, violence, and

oppression of marginalized populations (Arinder, 2020; Brabeck & Brown, 1997). Feminist theory progressed into a vital human rights movement that sought to change and extinguish the imbalances forced on marginalized populations (Leavy & Harris, 2019). Feminist theory strives to eliminate oppressive schemas by examining and reflecting on how people interrelate within specific systems and promote diversification of the human experience (Arinder, 2020).

Brief History of Feminist Theory

The origins of feminist philosophy date back to ancient times (400-200 B.C.) with Pythagorean, Aesara of Lucania, whose investigation of human existence encompassed aspects of women's experiences (Disch & Hawkesworth, 2016; Waithe, 1987). According to Waithe's (1987) study of women philosophers, Aesara developed a natural law and justice theory that embraced the individual, family, and society. Women played an active role in the creation of early Pythagorean philosophy and actively participated in society (Waithe, 1987).

Moving from ancient women philosophers to modern and contemporary women philosophers, one of the earliest publications attributed to feminist ideology was written in 1792 by Mary Wollstonecraft, *A Vindication of the Rights of Woman*. Wollstonecraft wrote this book in response to a report at the French National Assembly in 1791 by French diplomat Charles Maurice de Talleyrand-Périgord, which specified that a domestic education was all a woman needed (Enns, 2004; Waithe, 1987; Wollstonecraft, 1792/2010). Advocating for the rights of women and being one of the first to demand equal rights before "feminist" or "feminism" was a "thing," Wollstonecraft argued a great misery has occurred due to the inattention to women's education (Disch & Hawkesworth, 2016; Wollstonecraft, 1792/2010). She argued that "femininity" was a cultural construct that negatively influenced women's already limited access to education (Enns, 2004; Weedon, 2003). Wollstonecraft challenged that knowledge, integrity,

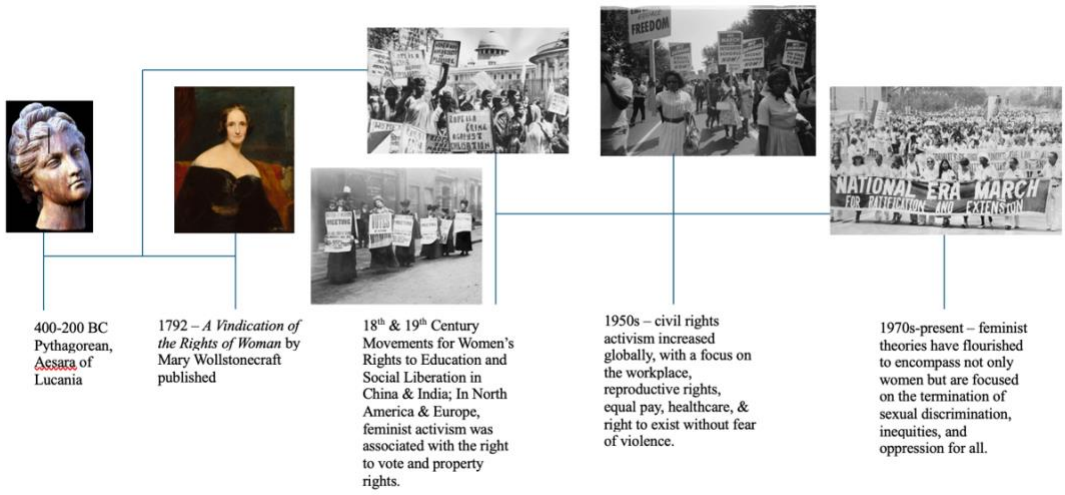
reason, and virtue would be lost if women did not receive equal education as men. Furthermore, Wollstonecraft emphasized that women would depend less on men in adulthood, be an asset to society, and not be subjected to condescension if girls were allowed the same educational opportunities as boys. The goal was not for women to overpower men but to have power over themselves (Wollstonecraft, 1792/2010).

Typically, feminist activism was related to women's right to vote and property rights, which received substantial success in North America and Europe (Bell et al., 2018). But oppression of women, women's voices, physical and mental health, and women's rights, to name a few, are not exclusive to the United States (UN Women, 2022). In the 18th century and early 19th century, there were movements for women's rights, rights to education, and social liberation in China and India (Disch & Hawkesworth, 2016). In the 1950s, civil rights activism increased worldwide, focused on the workplace, reproductive rights, equal pay, access to healthcare, and the right to exist without fear of violence (Bell et al., 2018).

Since the 1970s, feminist theories have flourished to encompass not only women but are focused on the termination of sexual discrimination, inequities, and oppression (Arinder, 2020; Leavy & Harris, 2019). Basic human necessities denied to women include health care, primary education, and safety within their homes from violence (UN Women, 2022). Women are discriminated against globally and lack adequate representation in political matters and decision-making. More recently, efforts to encourage gender equality and empowerment of women globally are on the rise (UN Women, 2022). A division within the United Nations, UN Women (2022), the United Nations Entity for Gender Equality and the Empowerment of Women, was developed in 2010 to achieve a more inclusive world. The following is a figure is a timeline depicting a brief history of feminist theory.

Figure 2

A Brief History of Feminist Theory



Major Feminist Theories

Before a brief discussion of the major feminist theories can take place, a review of common principles of feminist theory is essential. Important concepts central to feminist theory involve sex, gender, race, discrimination, equality, difference, and choice (Arinder, 2020). Major feminist theories include liberal, radical, Marxist/socialist, postmodern/poststructuralist, multiracial, and intersectional (Andermahr et al., 2000; Arinder, 2020; Braidotti, 2003; Renzetti, 2018). Common principles embraced by all feminist theories include (a) gendered (feminine/masculine) attitudes and behaviors are socially constructed expectations of women and men as a means to organize social life; (b) inclusion of female viewpoints in all research as professionals or study participants; (c) assessment of criminal offenses, victimization, and criminal justice processing against intersecting social factors such as gender, race, ethnicity, social class, age, and sexual orientation; and (d) development of unbiased solutions that acknowledge and end power and oppression, and lead to change and empowerment (Arinder, 2020; Brabeck & Brown, 1997; Enns, 2004; Renzetti, 2018). Additionally, there is an emphasis

on self-awareness, self-care, care for others, shared power, transparency, respect, courage, and zero tolerance for discrimination in any setting (Enns, 2004; ActionAid.org, 2022).

Under feminist theory are a diverse array of specific forms of feminism based on current developments and trends, referred to as "waves." These waves are first-, second-, third-, and fourth-wave feminisms, each building on the one before (Leavy & Harris, 2019). Although the first use of feminism was found in 1880s France, it came into broader use in the United States in the 1970s by challenging the subordination of women physically, socially, spiritually, politically, civilly, and financially, calling on change of the prejudiced conditions women lived in (Disch & Hawkesworth, 2016; Hughes, 2002; McCann & Kim, 2017). The following table outlines the four waves of feminism.

Table 2

The Four Waves of Feminism

	First wave	Second wave	Third wave	Fourth wave
Time period	Late 1800s-Early 1900s	Late 1960s-Early 1970s	Early 1980s-Early 2000s	2012-present
Philosophy	Liberal feminism	Radical feminism Socialist/Marxist feminism	Postmodern/poststructural feminism Intersectionality	Intersectionality
Key contributors	John Locke, John-Jacques Rousseau, Jeremy Bentham, John Stuart Mill, Mary Wollstonecraft, Gina Krog, Gloria Steinem, Shirley Chrisholm, Liz Carpenter	Betty Freidan, Gloria Steinem, Audre Lorde, Andrea Dworkin, Catherine MacKinnon, Alice Walker Angela Davis, Clara Fraser, Simone de Beauvoir	Rebecca Walker, Judith Butler, Eve Ensler, Germaine Greer W.E.B. DuBois, Sojourner Truth, Kimberle Crenshaw, Anna Julia Cooper, Patricia Hill Collins	W.E.B. DuBois, Sojourner Truth, Kimberle Crenshaw, Anna Julia Cooper, Patricia Hill Collins, Gloria Anzaldua, Dorothy Smitha
Focus	Right to vote Equal and fair environment between genders (educational, occupational, pay) End of gendered stereotypes Promotion of human dignity Individual freedom Autonomy Self-sufficiency Equality Justice	End of male dominance End of antiquated sex role ideologies Female empowerment Equal pay Reproductive rights Promoted economic and political equality Male dominance associated with capitalism, unequal balance of wealth, and financial dependence on men	Individual perception over specific identity The body is a social construct and to be regarded for its diversity Language creates meaning Personal and interpersonal dynamics within social groups Violence against women Reproductive rights End systemic oppression Social, cultural, and demographic characteristics mold women's experiences Improve inequities in healthcare and public policy	Enables the diversity of women's voices to be heard Internet used to lift women's voices Modern technologies allow for access to early feminist philosophers Self-valuation and self-definition used to resist oppression Differences used to oppress women

First-Wave Feminism: Liberal Feminism

The establishment of a more equitable and fairer environment between men and women, and the dissolution of classic (and sometimes harmful) gendered stereotypes, the promotion of human dignity, individual freedom, autonomy, self-sufficiency, and equality are the goals of liberal feminism (Enns, 2004). Liberal feminism has its roots in the philosophy of equal rights, individualism, liberty, and justice constructed by Locke, Rousseau, Bentham, and Mill (Andermahr et al., 2000). Liberal feminism is the "first wave" of feminist ideologies beginning in the late 19th to early 20th century, which focused on women gaining the right to vote and equal rights and opportunities for women in the United States, among other countries (Bhavani & Coulson, 2003; Leavy & Harris, 2019; McCann & Kim, 2017). Oppression of women, as argued by liberal feminism, results from fixed gender-role conditioning and unfounded biases against women, which lead to the acceptance that women are not as intellectually or physically capable as men (Enns, 2004). The most significant issues for liberal feminists were equal availability of educational and occupational opportunities, fairness in pay, and gender equality across all areas of life (Weedon, 2003). Enns (2004) argued that gender socialization and unfounded prejudice against women, fundamental causes of sexism or sexist thought, are extinguished through thoughtful discourse, reconstruction of mindsets about men and women, and policies that promote empowerment and equality for both men and women. Promoting human dignity, equality, self-fulfillment, autonomy, and rationality and reforming systems restricting individual freedoms are consistent themes in liberal feminism.

Second-Wave Feminisms: Radical Feminism and Socialist/Marxist Feminism

Radical feminism was considered the "second wave" of feminist ideologies, constructed out of frustration over North American leftist politics of the late 1960s and early 1970s

(Andermahr et al., 2000). Ehlers (2016) and Enns (2004) contended that what set radical feminism apart from other forms of feminism was the belief that (a) the leading form of oppression was viewed as oppression toward women; (b) globally, women shared a collective bond due to this oppression; (c) elimination of gender oppression is the most difficult; and (d) women and men are profoundly different, and radical social change is essentially needed to end patriarchal control. Radical feminist initiatives were responsible for exposing the level of violence against women (e.g., women's refuge movement, participation in the civil rights movement, development of rape crisis centers, consciousness-raising groups, marches such as "reclaim the night," women-centered events, abortion rights), and saw the beginnings of a powerful women's health movement, "our bodies ourselves," with a battle cry of "Equality Now!" (Andermahr et al., 2000; Enns, 2004; Leavy & Harris, 2019). The radical feminist movement embraced the idea that the oppression of women is directly due to male power, which had to be acknowledged and understood (Andermahr et al., 2000; Disch & Hawkesworth, 2016; Leavy & Harris, 2019; Montoya, 2016). Radical feminists worked to identify the negative factors placed on women's lives, antiquated sex role ideologies within domestic life (e.g., misappropriation of women's bodies, work, marriage, housework, childcare), by the patriarchy in the interest of men (Ehlers, 2016; Enns, 2004; Nicholson, 2010/2017; Weedon, 2003). Radical feminists sought to separate women from male-dominated control of their minds, bodies, and speculative prejudices to empower the value of the female body undermined by patriarchy (Enns, 2004; Weedon, 2003). Women were enabled to have greater knowledge of their bodies, learn from other women's experiences through their stories, and empower women to push for necessary changes to improve women's health and quality of life (Boston Women's Health Book Collective, 2011; Grigg & Kirkland, 2016).

The second form of feminism, prominent during the 1960s and 1970s, was socialist/Marxist feminism. Socialist feminism viewed patriarchy as the system of oppression against women, whereas Marxist feminism placed greater importance on "class" as the system of oppression toward women (Hennessy, 2014; Kantola, 2016). Socialist feminists argued against individualism, promoted economic and political equality and commitment to the common good, and claimed women's oppression was due to male domination within the confines of capitalism, the unequal balance of wealth, and women's financial dependence on men (Andermahr et al., 2000; Enns, 2004; Eisenstein, 1979; Gardiner, 1979; Hughes, 2002). Additionally, for some feminists, motherhood was oppressive (Hughes, 2002). Women were financially dependent, overwhelmed, and isolated by the duties of childcare, leading to symptoms of depression. For many women, navigating career professional and motherhood became an either/or decision or working the "double shift" (Hughes, 2002).

Marxist criticism of capitalism influenced socialist feminists who claimed women were oppressed, exploited, and alienated in quantifiable and financial ways under capitalism (Enns, 2004; Hennessy, 2003, 2014). Despite making up about half of the world's population, women are among the poorest in the global society, particularly in the Third World (Eisenstein, 1998; Talpade Mohanty, 2003/2017). Globally, women provide two-thirds of the world's work (paid or unpaid) but only bring in one-tenth of income. Additionally, women own less property, have a higher refugee population, live in deplorable conditions, are forced into prostitution or sexual slavery, and experience domestic violence and religious persecution. Further, most women were in sex-defined occupations, promotional opportunities were sparse, and there was a severe underappreciation and valuing of women's work, whether in paid or unpaid positions (Gardiner, 1979; Martin, 1986; Oksala, 2016). Women's work held less value, whether in the home or

outside of the house, particularly inside the home, as the work does not provide a surplus value; nonetheless, women use goods purchased with wages earned (Bergeron, 2016; Hennessy, 2003). Women were encouraged to share their experiences of subordination to demonstrate a united front of solidarity and sisterhood (Kruks, 2014).

Third-Wave Feminisms: Postmodern/Poststructural Feminism and Intersectionality

Postmodern/poststructuralist feminism grew from profound changes in social, economic, and political structures due to the increased globalization of capital, considered the third wave of feminism (Enns, 2004; Truth Goodman, 2019; Wollmark, 2003). From the 1980s through the early 2000s, postmodern feminism became a powerful influence in feminist theory (Enns, 2004). Postmodernism focuses on individual perceptions rather than specific identities, whereas poststructuralism focuses on personal and interpersonal dynamics within social groups (Leavy & Harris, 2019). In postmodern/poststructuralist feminist research, the lived experiences of women and allies are brought together to acknowledge their varied subjective perceptions (Leavy & Harris, 2019).

The primary focus of postmodern feminism is on the individual experiences of their self-identification (i.e., woman) to gain further insight and understanding of personal perception (Leavy & Harris, 2019). During this time, the source of oppression was considered the symbolic order (e.g., race, sex, class, age) of individuals and the substantial consequences it brought for those oppressed, highlighting the need to challenge the socially constructed symbolic order (Leavy & Harris, 2019). The body made up of interconnecting significance and symbolic forces is viewed as socioculturally constructed and to be celebrated in all of its diversity (e.g., race, sex, class, age) and power without neutralizing the differences (Braidotti, 2003; Leavy & Harris, 2019).

Language is fundamental in postmodernist feminism and is used to create meaning; however, small or extensive shifts in meaning can change over time due to various situations (Andermahr et al., 2000; Enns, 2004; Hughes, 2002; Leavy & Harris, 2019; Truth Goodman, 2019). Within postmodernist feminism, truth is subjective and does not always represent reality or objectivity. According to Tong (2014), language does not represent reality; however, she argued that reality is built off of language, which is needed for authenticity to endure. Truth is influenced by history, social milieu, and how life experiences and worldviews impact the individual (Enns, 2004). However, Davis (2007/2017) criticized postmodern feminism's informal language implementation to influence women's societal practices. She argued that more harm is created when women's subjective experiences are discredited as an important resource for epistemological knowledge. Furthermore, Davis challenged the belief that discussion and dialogue would inevitably mean the relinquishment of women's agency; however, OBOS empowered women with the knowledge to make critical medical decisions and navigate oppositional feminist politics to make health decisions.

Another criticism was that the lack of inclusion of women of color (Chin & Russo, 1997). Intersectionality, a term initially developed by Kimberlé Crenshaw in 1989, highlights the magnitude of power, oppression, and violence against African American women and emphasizes how established systemic oppression within institutional environments made it difficult for women of color to discuss and meet their needs (Cho et al., 2013; Ciurria, 2020; Crenshaw, 1991; McCann & Kim, 2017; Tong, 2014). Before its inception, during the late 1960s through the early 1980s, many scholars and activists embraced the precepts of intersectionality despite the absence of the term (Collins & Bilge, 2016; Leavy & Harris, 2019; see hooks, 1984). Intersectionality uses a theoretical, analytical, and practical lens to unravel societal problems and

provide effective problem-solving interventions to cultivate a better understanding of our intersectional constructs (Ciurria, 2020; Collins & Bilge, 2016; Crenshaw, 1991; Leavy & Harris, 2019; Lykke, 2010). Under the lens of intersectionality, oppressive factors (e.g., race, gender, class, sexual orientation, age, color) are evaluated as they are simultaneously used to produce the unjust practices of those in power (Ciurria, 2020; Collins & Bilge, 2016; Crenshaw, 1991; Hekman, 2019; Hurtado, 2019; Lykke, 2010; McCann & Kim, 2017). Additionally, sexism, racism, and classism created divisions and disagreements that alienated women from each other within the feminist movement (Hawkesworth & Disch, 2016; hooks, 1984; Söderbäck, 2019). Influences such as religion, nationality, and citizenship status are now considered along with primary factors such as race, gender, class, and sexuality that interact and impact women's lived experiences (Code, 2014; Crenshaw, 1991; Tong, 2014). Health and illness, from an intersectional feminist viewpoint, gained increased interest due to inequities and the need for improved practices in health care, clinical practice, and public policy (Collins & Bilge, 2016).

Fourth-Wave Feminisms

The fourth and present wave of feminism began in 2012, driven by younger activists and increased internet use to expose gender discrimination and bring awareness (Maclaren, 2015; Munro, 2013; Phipps, 2019; Wanzo, 2016). Women of color were critical of those who supported White feminist ideology and insisted on an intersectional approach, which acknowledges the various characteristics of identity (i.e., race, class, ethnicity, gender, sexual orientation) to evaluate critical issues brought to awareness by feminists (Vickery, 2018). Furthermore, intersectionality enables the diversity of women's voices can be heard, thus discouraging the outdated assumption that straight, white, middle-class feminists speak for all

women and that they set the norm through which other women are measured (Maclaren, 2015).

The internet is used to bring awareness to stories of oppression through personal blogs or vlogs, photoblogs, social media, life journals (e.g., YouTube, Facebook, Twitter, Snapchat, Instagram, Tumblr), and social networking (Leavy & Harris, 2019; Locke et al., 2018; Munro, 2013; Phipps, 2019, Wanzo, 2016). Those who seemingly had no voice in the past (e.g., women of color, sex workers, transgendered) can share their stories through digital media to challenge dominant ideologies. Digital media will allow for easier access to resources, which has changed how feminist scholars conduct and gather research and how their research is disseminated (Leavy & Harris, 2019; Maclaren, 2015; Phipps, 2019; Vickery, 2018; Wanzo, 2016). Additionally, written works of early feminist philosophers are more accessible because of these modern technologies, allowing for further expansion of contemporary feminist thought through publishing, conference presentations, and teaching special interest courses on early feminist philosophers (Boyle, 2021).

The internet captures a broader audience to bring awareness to women's issues or share the writings of feminist philosophers. For example, Phipps (2019) highlighted the tragic story of Leelah Alcorn, an American trans-female who, in 2014, ended her life. Leelah described her personal experience of utter cruelty due to "conversion" therapy (an ineffectual form of practice used to transform an individual's sexual orientation, gender identity, or gender expression to fit that of heterosexual, cisgender norms, which carries substantial psychological harm; Higbee et al., 2022). Blogs such as The Mod Squad Group, Project Vox (Duke University), New Narratives in the History of Philosophy project, and Extending New Narratives Partnership promote the works of feminist philosophers to tell the stories of women who were subjected to oppressive practices (Boyle, 2021).

Research Gap

Studies have been produced to establish the efficacy of R/S on various physical and mental health challenges of participants of all ages and backgrounds. R/S has been found to affect participants' physical and mental health, coping positively, and overall functioning. Many participants of these studies expressed an interest in the inclusion of R/S interventions into their counseling experience (Hook et al., 2010; Jennings et al., 2013; Koenig et al., 2014; Pearce & Koenig, 2013; Propst et al., 1992; Stanley et al., 2011; Tulbure et al., 2018). However, there is little to no research on the lived experiences of PM Christian women about their emotional and spiritual health. But some researchers have argued that reliance on R/S, for many participants, eased symptom development and intensity of the physical illness (Pimenta et al, 2014; Steffen, 2011). R/S are fundamental to a client's worldview and must be explored in the intake, assessment, and treatment process (Paterson & Francis, 2017). Thus, research and advocacy are needed.

Summary

Based on existing literature, the following conclusions can be extrapolated: menopause is a natural biological process, a significant life event, and experienced globally by millions of women signifying the end of their fertility (Grochans et al., 2018; Kopciuch et al., 2017; Muslić & Jokić-Begić, 2016; Onder & Batigun, 2016; Sandilyan & Dening, 2011; Sharma & Mahajan, 2015; Steffen, 2011). Three distinct phases make the process of menopause: premenopause, PM, and postmenopause. Associated side effects of each stage of menopause vary from person to person but affect the physical, mental, social, and spiritual lives of menopausal women resulting in decreased quality of life (Frey et al., 2013; Muharam et al., 2018; Onder & Batigun, 2016; Sandilyan & Dening, 2011; Sharma & Mahajan, 2015). The bio-psycho-social-spiritual model

was used to describe these phases of menopause to provide an all-inclusive view of how interconnected these processes are in the human body (Engle, 1997; Porter, 2020; Saad et al., 2017). Due to the oppression of women throughout the years, old beliefs and attitudes about women, their health, and their place in society, continue to be a problem, particularly in the medical field; however, through the efforts of feminist leaders such as Mary Wollstonecraft, Sojourner Truth, Susan B. Anthony, Harriet Taylor, Elizabeth Cady Stanton, Zillah Eisenstein, Gloria Steinem, bell hooks, Betty Friedan, Judith Butler, Gloria Rubin, Mary Gergen, Kimberlié Crenshaw, among many others, have fought for women's rights and the rights of the marginalized (Enns, 2004; Hennessy, 2014; Kantola, 2016; Weedon, 2003).

A significant amount of literature has concentrated on the physical, medical, and mental aspects of menopause exists; however, specific research concerned with the lived experiences of women during PM and the benefits of protective factors (e.g., mental health counseling, R/S, self-care, social support) is lacking. While there are advantages of incorporating spirituality into the bio-psycho-social model, spirituality is not universally explored for those seeking treatment for the negative symptoms of PM. Millions of women are significantly affected by menopausal symptoms worldwide every year, and many women who seek treatment report that they are given false or disingenuous information or that their concerns are dismissed, leaving them disappointed and discouraged. According to feminist theorists, the dismissal of women's health concerns is due to the residual patriarchal control of the medical field (Enns, 2004; Hennessy, 2014; Kantola, 2016; Weedon, 2003). Additional research is needed to explore the lived experiences of women during PM to gain an understanding of how they have experienced this time in their lives; the good times, difficulties, stressors, coping mechanisms, use of protective factors, and possibly any unmet or unexplored needs on how the mental health profession can

effectively advocate for women in the MT. Research on women's lived experiences in PM has been sparsely explored with regard to the benefits of protective factors (e.g., mental health counseling, R/S, self-care, social support).

This phenomenological qualitative study explored the lived experiences of PM Christian women from a bio-psycho-social-spiritual perspective through the lens of feminist theory. The following RQs were posed to answer this qualitative study's central question "What are the physical, mental, social, and spiritual lived experiences of PM Christian women?": How would PM Christian women describe their physical health during this time? How do PM Christian women describe their mental health during this time? What were the social/sexual experiences of PM Christian women? What did PM Christian women experience in their R/S life? Implications for mental health counselors are discussed and will include the impact of mental health counseling, how protective factors influenced coping, and directions for future advocacy for PM women by the mental health profession. Personal interviews with PM Christian women were conducted with each participant to gain insight into their lived experience during this phase. Data collection and themes identified will empower other PM women who have been reluctant to receive treatment and assist mental health counselors in their work with PM women. Based on the results of this study, mental health counselors will be equipped with a better understanding of how to work with PM women; support programs can be developed to educate, empower, and encourage PM women to know their symptoms, discuss their situation without stigma, and increase their overall physical, mental, social, and spiritual well-being.

CHAPTER THREE: METHOD

Overview

Many studies focused on the phases of menopause (pre-, peri-, post-) take a quantitative approach when investigating symptoms or treatment outcomes. Literature dedicated to the lived experiences of Christian women during PM is lacking or outdated. This phenomenological qualitative study sought to explore the lived experiences of PM Christian women. The current study uncovered participants' lived experiences (i.e., perceptions, challenges, relationships with family and friends, social supports, resources, spirituality, coping mechanisms) during the MT. This study provides practical information to destigmatize the discussion of menopause, empower PM Christian women to make their challenges and needs known to their medical and mental health providers, and offer ways to work with PM Christian women from a mental health standpoint. This chapter will describe the methodology used for this study, which includes the rationale for the research design, RQs, setting, participants selected, the role of the researcher, data collection and analysis, discussion of the study's trustworthiness, and ethical considerations.

Research Design

This study was designed to understand the lived experiences of PM women from a bio-psycho-social-spiritual perspective and the coping skills used to manage symptoms. To obtain significant experiences of PM Christian women, find meaning in their unique perspectives, and advocate for the individual needs of PM Christian women, a qualitative phenomenological approach was needed. Methodological details are discussed in the following sections.

Introduction and History of Phenomenology

Edmund Husserl was a German philosopher whose work led to the theoretical method of phenomenology, connecting human phenomena when examining human experience (Flood,

2010; Giorgi, 2008a; Giorgi et al., 2017; Mapp, 2008; McLeod, 2011; Wertz et al., 2011). The focus of Husserl's phenomenology is the discovery of the meaning and essence of the phenomena based on common themes gleaned from first-hand lived experience (Flood, 2010; Giorgi, 2012; Häfner, 2015; Mapp, 2008; Moustakas, 1994; Neubauer et al., 2019; Reeder, 2009; Tkachuk et al., 2019; Wertz, 2005). The information provided enables the researcher to have as close to an understanding as possible regarding the phenomena without their own experience. Over the years, other philosophers, methodologists, and psychologists have added to, refined, and revised phenomenological approaches developed from Husserl's philosophy (e.g., Martin Heidegger, Maurice Merleau-Ponty, Jean-Paul Sartre, Amedeo Giorgi, Hans-Georg Gadamer, Max van Manen, Clark Moustakas; Duquesne School; Flood, 2010; Giorgi, 2008b, 2012; McCleod, 2011; Sloan & Bowe, 2014).

The purpose of phenomenological research is for the researcher to explore phenomena through the lens of those who lived the experience (Moustakas, 1994). General assumptions of phenomenology include the challenge to form a view of the evidence that is both reflective subjective and scientific objective based on lived experience (Reeder, 2009). Phenomenology is driven by human experience (i.e., perception, thought, memory, imagination, emotion, desire, a consciousness of self, behavior, social activity, speech), what Husserl referred to as "intentionality" (Husserl, 1954/1970; Moustakas, 1994; Neubauer et al., 2019; Reeder, 2009; Smith, 2018). People experience phenomena through intentionality or consciousness (Moustakas, 1994), which determines the meaning or content of the phenomenon for that person (Antonelli, 2022; Häfner, 2015; Moustakas, 1994; Smith, 2018). Phenomenologists are interested in "perceived reality" and find that a participant's distortions are more dynamic than truthful insights into a phenomenon (Giorgi, 1994). Descriptions and perceptions are sought after rather

than analyses, explanations, and interpretations of the event (Giorgi, 1994; Moustakas, 1994; Tkachuk et al., 2019). The researcher continuously employs a self-critical examination of goals and methods to clarify and refine their view to understand the meaning of the experience itself (Flood, 2010; Reeder, 2009). Meaning is derived through Socratic questioning (i.e., to gain clarity, insight, understanding), then divided into themes (Beck, 1995; Moustakas, 1994; Overholser, 2018). Phenomenology does not aim to contribute to or expand empirical understanding (Reeder, 2009; Zahavi, 2019). Nevertheless, phenomenology has provided essential findings in various disciplines of social sciences (e.g., psychology, sociology, and anthropology, among others).

Transcendental, Descriptive, Eidetic

The focus of Husserl's transcendental phenomenology, the discovery of the meaning and essence of the phenomena, occurs through informal one-on-one interviews to obtain personal accounts of the *what* and *how* (description) of the experience (Giorgi, 2012; Häfner, 2015; Mapp, 2008; Moustakas, 1994; Neubauer et al., 2019; Reeder, 2009; Tkachuk et al., 2019). Before these interviews, the researcher "brackets off" any assumptions or preconceived ideas regarding the phenomenon to take an objective view of the essences revealed or the "thing itself" (Byrne, 2001; Husserl, 1931/2012; McLeod, 2011; Moustakas, 1994; Reeder, 2009; Sloan & Bowe, 2014). Understanding the essence of the phenomena or lived experience creates a vital link between philosophical and scientific worldviews (Reeder, 2009). Phenomenology is a science used to better understand human beings and the world (Neubauer et al., 2019; Reeder, 2009).

Hermeneutic, Existential, Interpretive

Martin Heidegger advanced phenomenology through the development of existential or hermeneutic (interpretive) phenomenology (Mapp, 2008; Sloan & Bowe, 2014). Heidegger's

primary focus of phenomenology was an interpretive approach to the nature of Being (ontological) or the immediacy of life (Barua, 2007; Campbell, 2019; Flood, 2010; Heidegger 1975/1988). He suggested that the impetus of phenomenology should be on the survey of lived experiences (*dasein*; Barua, 2007; Flood, 2010). Heidegger argued that the subjective experiences of humans are connected to their culture, social network, political views, family background, collective life experiences, and other external influences (e.g., world events) and that those experiences prohibit an unbiased perspective (Byrne, 2001; Flood, 2010; Heidegger, 1926/1994; Sloan & Bowe, 2014; Zahavi, 2019). Rather than going through the process of bracketing, Heidegger suggested a "natural attitude," which he considered to be an essential aspect of philosophical inquiry (Barua, 2007; Heidegger, 1926/1994; Kinkaid, 2022; Mapp, 2008; Marder, 2018; McLeod, 2011; Moustakas, 1994). For Heidegger, the "natural attitude" was the lens through which one views and understands the world. His interest was to understand and appreciate the "essence" of daily life and how people fit in the world as "human beings" (existential; Heidegger, 1975/1988; Jelscha, 2018; Kinkaid, 2022; McLeod, 2011). Interpretation was assumed to be a basic structure of the experience and not an independent undertaking (Flood, 2010; Moustakas, 1994).

Study Approach

The methodological design that fits with the purpose of the study most appropriately was a phenomenological qualitative approach based on the work of Moustakas (1994). Before the interview process begins, the researcher begins the phenomenological reduction process. The stages include the epoché (bracketing), imaginative variation (eidetic reduction), and the synthesis of meanings and essences (Husserl, 1931/2012; Moustakas, 1994; Puligandla, 1970; Schmitt, 1959). In the epoché or bracketing stage of phenomenological reduction, the researcher

sets aside or suspends any prejudgments, presuppositions, preconceived ideas, biases, beliefs, and influences about the phenomenon. This process is repeated throughout the study, as an obligation of the researcher is to maintain concentration, presence, and attention.

Methods of Preparation

Methods of preparation include the development of the RQ, a literature review of the professional research, the development of inclusion and exclusion criteria for selecting appropriate co-researchers (study participants), and adherence to the ethical principles concerning human science research (Moustakas, 1994). As an adherent of Husserl's transcendental descriptive phenomenology, Moustakas (1994) suggested that formulating the RQ in a phenomenological investigation should incorporate social meaning and personal significance to the researcher. The RQs are presented in clear, concise, and concrete terms, and keywords are defined, discussed, and refined to allow for transparency in the investigation. RQs are meant to unveil the essences and meanings of human lived experience, provide qualitative discoveries of behavior and experience, focus on the entirety of the participant (personal and passionate involvement), and qualitative phenomenological RQs offer enlightenment of the phenomena through detailed descriptions of the experience as opposed to quantitative measurements (Moustakas, 1994). Lastly, ethical considerations are implemented to include the nature and purpose of the study, informed consent documentation, discussion of confidentiality, and responsibilities of the researcher and participant are outlined and discussed before the commencement of the analysis (Moustakas, 1994).

Data Collection

In a qualitative phenomenological study, personal interviews are conducted to collect data about the phenomenon being explored (Moustakas, 1994). These interviews are typically

extensive, in person, telephonically, or via video conference (e.g., Zoom, FaceTime, Google Duo) and are recorded to allow for easier reference for the researcher. Interviews are informal and interactive conversations that usually consist of specific (bracketed) open-ended questions to give the participant the maximum opportunity to provide as much information as the participant is comfortable sharing about their experience of the phenomenon (Moustakas, 1994). Establishing a relaxed and trusting environment throughout the interview is essential for participants and is the researcher's responsibility. Suggested activities to begin a phenomenological interview are brief meditative exercises (e.g., yawn and stretch, sit and observe, wash your hands, mindful breathing, loving-kindness or chair meditation, 4-7-8 or box breathing, mindful listening; Kane, 2023; Moustakas, 1994). Next, the researcher requests the participants concentrate on their experience, particularly on specific aspects of their experience. Once the participant has had time to focus on their experience, they are asked to describe their experience fully.

Moustakas (1994) suggested developing comprehensive questions to allow participants to provide essential information about their experience, which he described as a general interview guide. The general interview guide should consist of questions about what significant incidents or people the participant observed that stood out during their experience, how the participant was directly affected by their understanding of the phenomenon (i.e., physically, mentally, emotionally, cognitively, relationally, spiritually), and how people in the participants' lives were intimately affected because of the experience. Lastly, researchers should follow up with the participants to ensure all critical information about their experience is shared (Moustakas, 1994). Upon completing the comprehensive interview guide, researchers conduct and record extensive personal interviews focused on participants' experiences of the phenomenon (Moustakas, 1994).

Organization and Analysis of the Data

Once the data are collected, the data are organized for analysis. The aim is to develop distinctive and integrative descriptions of the physical and perceived experiences of the phenomenon and synthesize these meanings and essences. The participants' statements are gathered and given equal value during this stage (horizontalizing). Irrelevant or repetitive comments are removed to reveal the phenomenon's interwoven significance and unchanging components (Husserl, 1931/2012; Moustakas, 1994; Puligandla, 1970; Schmitt, 1959). Emphasis is placed on the characteristics of the experience; however, the challenge for the researcher is to determine the meaning of the phenomenon. But imaginative variation allows the researcher to develop themes from the detailed participant descriptions of their experience (Moustakas, 1994). The final stage of phenomenological research is the natural amalgamation of the essential textural and structural descriptions. The synthesis of meaning is a comprehensive assertion of the essences derived from the experience of the phenomenon in its entirety from those who lived through the experience (Moustakas, 1994). The synthesis of the textural and structural essences comes after an extensive imaginative and reflective analysis of the experienced phenomenon. It is representative of a specific timeframe from the researcher's standpoint (Moustakas, 1994).

RQs

RQs were prepared to provide specificity of what is being explored, opportunities for understanding, new learning, and developing new meaning that can be added to the body of literature (Flamez et al., 2017). These questions were used to uncover PM Christian women's multifaceted experiences during PM. The goal is to better understand how PM Christian women navigate the various aspects of their world. These questions focused on the physical (medical), emotional (mental), social (relationships), and R/S experiences of these women's lives through

the lens of feminist theory.

Driving the focus of this qualitative phenomenological study is one question broken down into four parts: “What are the lived experiences of PM Christian women from a bio-psycho-social-spiritual perspective?

Central RQ: “How would PM Christian women describe their physical, psychological, mental, emotional, relational, and R/S lived experiences?”

RQ 1: How do participants describe their physical health during PM?

RQ 2: How do participants describe their mental health during PM?

RQ 3: What were the social/sexual experiences of PM Christian women?

RQ 4: What did PM Christian women experience in their R/S life?

Setting

This phenomenological qualitative study explored the lived experiences of PM Christian women. The participants for this study were personal contacts of the researcher as well as those solicited from Facebook and CESNet Listserv. The interviews took place over Zoom for Healthcare to ensure the confidentiality of each participant. The participants selected and the interview setting provided an appropriate population of PM Christian women and offered a safe, comfortable, neutral atmosphere for participants to discuss their experiences liberally.

Participants

The sampling method utilized for this study was purposive, criterion based, and convenient. Participants were selected due to their availability for a specific purpose based on predetermined criteria to procure a representative sample (Flamez et al., 2017; Moser & Korstjens, 2018; Patton, 2015; Peoples, 2021). Participants were chosen based on their knowledge and experience as PM Christian women and their willingness to share their

experiences. The participants for this study were selected based on the following inclusion criteria: medical diagnosis or presence of PM symptoms by non-surgical means, have a Christian faith, assigned female at birth, and over 35 years old.

According to Patton (2015), participant samples in qualitative research are significantly smaller than in quantitative research studies and are selected for a precise purpose. In a qualitative phenomenological study such as this, the goal was not to acquire a large or specific sample size; however, the goal is saturation. The sample size was based on informational considerations; therefore, sampling was concluded once new information is no longer obtained (Flamez et al., 2017; McLeod, 2011; Patton, 2015). A reasonable estimation of participants at saturation was about 10.

The participants were solicited from those of the researcher's acquaintance via private phone conversation, text, email, or Facebook Messenger, in addition to CESNet Listserv. Personal semistructured interviews were conducted via Zoom for Healthcare, a HIPAA-compliant video conference platform, to ensure confidentiality and privacy. The estimated sample size was expected to be more than appropriate to saturate the information collected (Patton, 2015; Peoples, 2021). The sampling technique utilized for this study is believed to represent the greater population of PM Christian women.

Procedures

Before the commencement of this study, approval from Liberty University's Institutional Review Board (IRB) was obtained (Appendix A). Upon IRB approval, contact with potential participants took place. Two of the participants were of the researcher's acquaintance, while eight participants were strangers to the researcher. A recruitment letter (Appendix B) and a QR code to the screening questionnaire (Appendix D) created on Google Forms were emailed to

participants after initial contact to determine whether each participant met the criteria for study participation. Throughout the study, the researcher kept a research journal to document any thoughts, feelings, or emotions they are experiencing related to the study to support the researcher and keep the researcher free of any preconceived judgments and suppositions.

All interested participants completed and returned questionnaires via email. Qualified participants were notified by email to schedule an interview. Before the initial interview, an information sheet (Appendix F) was distributed via email to all participants outlining the purpose of the study and assurances of confidentiality and privacy. Any questions concerning the purpose of the study, confidentiality, and privacy were addressed before the commencement of the study. This information was reiterated at the initial interview with each participant, along with my role as the researcher/interviewer, not as a counselor or friend during the interview process.

Personal interviews were conducted via Zoom for Healthcare, a HIPAA-compliant video conferencing platform, and each interview was recorded using the recording tools for this platform. Each interview is face-to-face, with only the researcher and participant in their respective spaces for confidentiality and privacy. The researcher and participant ensured an appropriate internet connection was obtained for the best audio and visual purposes during the recording. Before the interview, the recording software on Zoom for Healthcare was tested. Recordings enabled the researcher to listen and watch each interview to document tone, volume, and inflection of voice, speech rate, vacillations, emotional utterances (e.g., crying, laughing, irritation), and non-verbal communication (e.g., facial expressions, body position, movements) that communicate meaning. It was estimated that a 2-hour interview time was appropriate to obtain sufficient data from participant responses; however, most interviews took place in about 1 hour. Participants were given time to provide open and honest responses; however, their time

was respected to avoid scheduling conflicts.

During the personal interviews, to prevent any bias or influence on the participants, the researcher did not offer any emotional support or feedback other than to say, "Thank you," following the participant's response. After each interview, the video recordings were transcribed, which was invaluable to the researcher to hear and see the words participants used to describe their experiences. Interviews were transcribed using Zoom for Healthcare and analyzed using Delve, a qualitative data coding and analysis software program. Central themes from the data collected were extracted from the analysis, and the researcher's interpretations were documented and discussed, with the final results presented to the dissertation committee.

Interview questions (Appendix G) were designed to elicit the most information about the participants' lived experiences as PM Christian women (e.g., good and bad experiences, challenges, pros and cons of this life stage, perspectives, coping mechanisms, physical health, mental/emotional well-being, social support, R/S). The expectation was that these questions would provide sufficient data to understand the sample participants' perceptions of their lived experiences as PM Christian women. As mentioned, a researcher's journal was kept throughout this study to record the researcher's reactions, responses, thoughts, feelings, and perceptions of each interview. It was part of the research data.

The Researcher's Role

The role of the researcher in phenomenological research design is to identify a phenomenon to investigate (Bliss, 2016). There is no shortage of phenomena worldwide, which come in many forms (e.g., personal, global, cultural, local, gender, age, race). According to Patton (2015), qualitative exploration is personal, and the researcher is the analysis instrument. The researcher's background, experience, worldview, education, skills, level of empathy, cross-

cultural understanding, interpersonal interactions, and critical analysis all hinge on the integrity of the findings (Patton, 2015). Therefore, careful reflection and interpretation of the data collected can be affected by the researcher's attitudes, beliefs, social interactions, worldview, current activities, and interests, and what the researcher decided to study is part of the qualitative methodology.

To ensure objectivity, the researcher bracketed off any preconceived notions, a priori assumptions, ideas, thoughts, attitudes, and beliefs that may influence the researcher and affect the research's integrity (Moustakas, 1994; Patton, 2015). As a PM Christian woman, the researcher has had experiences with bio-psycho-social-spiritual symptoms of PM (e.g., mood irregularities, difficulties with concentration, headaches, hot flushes, sleep issues). However, the researcher was curious to know how other Christian women experienced PM—How did physical health, mental health, social interactions, and R/S affect or influence the participants' experiences? How were their experiences similar or different from the researcher's experience with PM? How did participants overcome stressors or challenges, and how did they cope with them? The researcher kept a research journal, which records the researcher's thoughts, feelings, biases, and responses throughout the study. By bracketing oneself, the researcher took an objective view of the essences that emerge from the data to make more explicit interpretations that lead to meaning.

Data Collection

Data were collected through personal semistructured interviews with each of the participants. Semistructured interviews consisted of predetermined open-ended questions augmented by follow-up or exploratory inquiries based on the conversation between researcher and participant (DeJonckheere & Vaughn, 2019). Questions were specific to biological,

psychological, social, and R/S perceptions associated with PM to enable a greater understanding of the participants' experiences.

Interviews

In qualitative research, phenomenological interviews are casual and informal but also interactive, like a conversation, mainly focused on the participant's lived experience of the phenomenon studied (Moustakas, 1994). The semistructured interviews include set open-ended questions that lead to additional follow-up questions to give the researcher a greater understanding of the participants' lived experiences (DeJonckheere & Vaughn, 2019). The purpose of the study, procedures, confidentiality, and the importance of the participants' openness during the interview are explained before the commencement of the study. Following introductions, an explanation was provided to help the participant understand the intention of the interview. Light-hearted but professional banter helped build rapport and helped the participant feel more comfortable with the researcher if necessary (Moustakas, 1994).

Interview Questions

Before IRB approval, interview questions were reviewed with the chair to ensure readability, clarity, and appropriateness to prevent intense negative emotions from participants. The intent of the personal interview is not to cause harm, thus violating the ethical standards of research. Participants were afforded a reasonable expectation of safety during the progression of the research study.

Part I of the interview questions aimed for the researcher to better understand how the participant self-identified (Question 1), their perceptions of PM in general (Question 2), and how PM has affected them personally (Questions 3-4; see Appendix G for the full list of questions and sections). These questions provided information on how the participants self-identified and

provided context for their individual lived experiences. The researcher inquired further with additional probing questions based on the participant's responses (DeJonckheere & Vaughn, 2019; Moustakas, 1994).

Part II of the interview questions concentrated on the bio-psycho-social-spiritual aspects of PM. The bio-psycho-social-spiritual model provides a theoretical approach to understanding clients' physical and mental health (Engel, 1997; Porter, 2020; Saad et al., 2017). The incorporation of R/S aided the researcher in obtaining a greater understanding of the participant, as many people rely on their R/S for coping despite being a fluid concept (Koenig, 2012; Saad et al., 2017). Furthermore, including R/S beliefs alters diagnostic and treatment planning, leading to increased quality of life. Utilizing the bio-psycho-social-spiritual model allows the researcher to add a human element to the scientific domain, thus allowing for a universal approach to treating clients (Engel, 1997; Porter, 2020; Saad et al., 2017). Questions 6 through 9 covered biological or physical aspects of PM. Questions 10 through 13 covered PM's psychological, emotional, and mental aspects. Questions 14 through 21 focused on the social aspects of PM. Finally, questions 22 through 25 focused on R/S aspects of PM.

Part III (Questions 25 and 26) of the interview questions explored treatment, coping strategies, and protective factors employed by participants during PM. Participants were asked to identify these factors and their effectiveness in dealing with the symptoms experienced from PM. Coping strategies or coping mechanisms are utilized to decrease stress, anxiety, depression, or other psychological or emotional difficulties (Millacci, 2017). Various coping strategies can aid in symptom relief. Coping skills come in many forms, ranging from positive (healthy) coping skills (e.g., managing emotions, gaining support, communicating, engaging in hobbies, prioritizing, delegating) to negative (unhealthy) coping skills (e.g., abusive behaviors, addiction,

avoidance of problems, self-harm, isolation). Protective factors enable the individual to positively adapt when faced with difficult situations or circumstances (Wilson, 2021). Protective factors are unique to each individual and aid in regulating emotion, make meaning, and promote interpersonal growth. Examples of protective factors include emotional awareness, emotional regulation, honesty, humility, anger management, one's purpose in life, R/S, family involvement and attachment, compassion, supportive social relationships, ability to forgive, physical development, self-esteem, community engagement, and boundaries and expectations for self and others.

Part IV of the interview questions centered on future recommendations. Question 27 asked the participant to reflect on what they want to know before entering PM. Question 28 is more general and asked participants what changes could be made to prepare women for PM better. Question 29 concluded the personal interview by thanking the participant for their willingness to be vulnerable in their responses and for the time they took to participate. Participants were asked for any final thoughts or closing remarks that could benefit the researcher in having a better understanding of the participant's experiences during PM. The participant's feedback was recorded, and the interview concluded.

Data Analysis

According to Peoples (2021), data analysis does not conform to phenomenological research as *analysis* means "break into parts," and in the qualitative phenomenological study, the goal is to understand the phenomenon as a *whole*. Phenomenological research is driven by human experience (e.g., perception, thought, memory, imagination, emotion, desire, a consciousness of self, behavior, social activity, speech) to illuminate the meaning and essence of the phenomena based on themes collected from first-hand lived experience (Flood, 2010; Giorgi,

2012; Häfner, 2015; Husserl, 1954/1970; Mapp, 2008; Moustakas, 1994; Neubauer et al., 2019; Reeder, 2009; Smith, 2018; Tkachuk et al., 2019; Wertz, 2005). Nevertheless, the overarching goals of data analysis are to gather, organize, and decipher the data collected. The goal of data analysis in qualitative phenomenological research is to accurately interpret the data collected clearly and recognizably to anyone who has experienced that particular phenomenon. The goal in this study was to identify patterns, themes, and connections within the data collection to bring awareness to the lived experiences of PM Christian women.

Steps taken by the researcher to analyze the data collected include reading and reviewing interview transcripts to understand the participants' stories while removing extraneous information (e.g., repeated statements; filler words such as "um," "uh," "well"; Peoples, 2021). Next, preliminary meaning units were generated based on the research topic and were characteristic of the phenomenon (Giorgi, 1997, 2000; Giorgi et al., 2017; Peoples, 2021). Meaning units are the parts of a unified description of the phenomenon. Participant descriptions were often extensive and required separation into meaningful parts for data analysis. Final meaning units or themes were then extrapolated based on the researcher's increased understanding of the data collected (Peoples, 2021). From a Husserlian perspective, how meanings, essences, and insight are formulated is highly important. Mental visualizations are how meanings and essences arrive at consciousness, with essences determined through the assistance of imaginative variation (Giorgi, 2006). Situated narratives, specific excerpts from each participant's story, were then organized into themes specific to each interview question (Peoples, 2021). The situated narratives were then unified to create general narratives of the participants' accounts. The goal was for all the participants' meanings to be highlighted. Lastly, a general description was given, which unites the main phenomenological themes generated from

the participants' lived experiences. The following sections will describe the researcher's plans for phenomenological reduction during the commencement of the study.

Phenomenological Reduction

To produce a successful phenomenological study, the researcher's methods and procedures required thorough organization, discipline, and logic. Procedures for preparation, data collection, organization and analysis of data, and synthesis of meanings and essences derived from the data were explicitly outlined in the literature (Giorgi, 1997, 2000, 2006; Giorgi et al., 2017; Moustakas, 1994; Peoples, 2021). The stages that were conducted during this study include epoché (bracketing), imaginative variation, and synthesis of meanings and essences (Husserl, 1931/2012; Moustakas, 1994; Puligandla, 1970; Schmitt, 1959). The following sections will provide further detail of epoché, imaginative variation, and synthesis of meanings and essences as it will relate to this study.

Epoché

The epoché process instructs the researcher to bracket off or set aside any preconceived biases or ideas of the phenomenon being studied from a fresh perspective (Byrne, 2001; Husserl, 1931/2012; McLeod, 2011; Moustakas, 1994; Reeder, 2009; Sloan & Bowe, 2014). During the personal interviews, the researcher kept a journal of their thoughts, feelings, perceptions, reactions, and ideas of the participants' interviews and stories. Additionally, the researcher took time before participant interviews to engage in self-care activities (e.g., pray, meditate, relax) to prepare for the interviews. In this context, the researcher was not a counselor but an investigator or reporter.

Imaginative Variation

The next stage helps to explain the question "How did the experience of the phenomenon

become what it is?" (Moustakas, 1994, p.80). The researcher is looking for the *how* and *what* of the phenomenon being experienced. The researcher will look for possible meanings of the phenomenon experienced through imagination, participants' descriptions, and different frames of reference to determine the basic narratives of the experience (Moustakas, 1994; Peoples, 2021). Imaginative variation enables the researcher to foster themes from participants' descriptions. Various truths emerge that are closely connected with the meanings after the experience of the phenomenon (Moustakas, 1994). Moustakas (1994) outlined four steps that were used in this study: (a) organize the essential influences that affect the textural implications; (b) identify primary themes that explain the appearance of the phenomenon; (c) study the wide-ranging perceptions that prompted thoughts and feelings related to the phenomenon (e.g., time, space, physical being in relation to self or others); and (d) search for examples that demonstrate unchanging structural themes that aid in the development of the essential explanation of the phenomenon.

Synthesis of Meanings and Essences

Lastly, the researcher reflected on the potential meanings of participants' experiences, synthesized the data collected, and constructed a comprehensive statement embodying the phenomenon's essence (Moustakas, 1994; Peoples, 2021). Care and caution were required to synthesize meanings; essences were just one part of the whole picture. A second look at the data took place to finalize the analysis, including a review of the researcher's journal and the transcripts of the personal interviews.

Trustworthiness

Qualitative research is messy, depends on comparatively fewer participants than quantitative research, and demands extensive analysis and interpretation from the researcher

(Williams & Kimmons, 2022). The researcher must provide sufficient explanation, maintain transparency, and produce enough evidence to support their findings. The researcher needs caution in how they conduct and report their work for accuracy and believability of their results. Several questions must be explored concerning credibility, generalizability, replication of the findings, and impartiality. Therefore, the following sections will discuss how trustworthiness was met in this study, including credibility, transferability, dependability, and confirmability (Peoples, 2021).

All participant interviews occurred with the same interviewer via Zoom for Healthcare (a HIPAA-compliant video conferencing platform). To ensure trustworthiness, triangulation (i.e., use of multiple sources of information), explanation of researcher bias (i.e., journaling), member checking (i.e., participants review the transcript of their interview), and providing detailed descriptions of the participants' lived experiences of the phenomenon took place (Peoples, 2021). Multiple sources of information were collected in the literature review; however, through personal interviews, additional data collected through this study added to the research on PM Christian women. Throughout this study, the researcher kept a journal documenting any emotions, biases, and preconceived ideas concerning the phenomenon studied. Participants were given opportunities to review their interview transcript to ensure their statements' accuracy. Lastly, detailed descriptions of participants' lived experiences were included to gain understanding and knowledge of their experience.

Credibility

For a study to be credible, it must be believable, authentic, and accurate (Peoples, 2021; Williams & Kimmons, 2022). The literature review revealed that there is much conflicting information on the phenomenon under investigation in this study. Additionally, many articles

and studies collected for the literature review were from quantitative studies. It was observed that very few, if any, qualitative studies on this topic have been conducted. Data collected through personal interviews provided further insight into the mental health of PM Christian women. Upon completion of the individual interviews, participants were allowed to review and approve their personal interview transcripts (member checking) and make corrections or clarify their statements (Peoples, 2021; Williams & Kimmons, 2022).

Another method to ensure the credibility of the current study is progressive subjectivity testing or explanation of researcher bias (epoché or bracketing; Peoples, 2021; Williams & Kimmons, 2022). The researcher of this study kept field notes, journals, reports and continually audited their biases, judgments, and preconceived opinions concerning the phenomenon as the researcher has their own experience. According to Peoples (2021), either the method was inappropriate or biased clouded the researcher's interpretation of the data if what was already known by the researcher concerning the phenomenon is reported. Discovery is needed for a qualitative phenomenological study to be credible.

Transferability

The inherent nature of a qualitative study does not lend itself to generalizability or a universal truth as in a quantitative study (Peoples, 2021; Williams & Kimmons, 2022). There are too many confounding variables to draw definite conclusions that can be applied to a similar phenomenon but at a different time. New insight is the desired result in qualitative studies, and these new insights can be transferred or applied to various circumstances. But in the case of transferability, the researcher is not the one to determine the applicability of the findings. Readers determine transferability based on how similar their perspective is to the researcher's conclusions. Researchers enable transferability for the reader by providing detailed descriptions

of the phenomenon (e.g., who, what, when, where how). Therefore, by providing rich details, the reader can better determine how the study findings can transfer to their unique situation or circumstance (Peoples, 2021; Williams & Kimmons, 2022).

Dependability

Consistency is vital when discussing the dependability of a qualitative study (Williams & Kimmons, 2022). Logic, reasoning, methods, and results must be stable. To ensure reliability, conceptualization of the study, data collection, interpretation of results, and documentation of the results reported are evaluated for carelessness and inattention. The current study presented a rationale for selecting the phenomenon observed, choosing participants, and interview questions used. Additionally, journals, field notes, archives, and reports are available for review or audit (Williams & Kimmons, 2022). Furthermore, by providing a comprehensive explanation of the research process, further research into this phenomenon can potentially yield similar results (Peoples, 2021).

Confirmability

The confirmability of a qualitative study depends on the study participants' support and the researcher's autonomy (Williams & Kimmons, 2022). Other means for enhancing the confirmability of a study include findings in the literature that validate the researcher's interpretations, larger sample size, repetition of the study in different settings, and assessment of study results to other evidence available. Nevertheless, it must be noted that study findings do not necessarily need to agree with the literature or other sources of information. Still, to be deemed credible, there must be a way to confirm study results. A confirmability audit can be conducted simultaneously as a dependability audit to verify the study's trustworthiness (Williams & Kimmons, 2022). To ensure confirmability in the current study, appropriate

literature was selected for the literature review that covered multiple views of the topic of investigation. Lastly, audits can also be conducted to determine confirmability and dependability with an independent auditor.

Ethical Considerations

The researcher utilized due diligence in adherence to the American Counseling Association (ACA) *2014 Code of Ethics*, the Texas State Board of Examiners of Professional Counselors *Code of Ethics*, and the IRB of Liberty University throughout this research study. Most importantly, the fundamental principles of professional ethical behavior (i.e., autonomy, nonmaleficence, beneficence, justice, fidelity, veracity), as defined by the ACA (2014), was respected during the study. Additionally, every effort was made to protect the participants' private health information and confidentiality of information shared in the personal interviews through the use of pseudonyms in the final publication, the use of a HIPAA-compliant video conference platform, and other appropriate safeguards to minimize unauthorized access to study data (ACA, 2014; Texas State Board of Examiners of Professional Counselors, 2023).

Counselors are encouraged to contribute to the profession's knowledge base through research and the dissemination of scholarship, leading to greater societal well-being (ACA, 2014). Counselors must support and participate in research efforts, minimize bias, respect diversity, and promote inclusion. Federal, state, and local laws, ethical principles of counseling associations, institutional regulations, and scientific standards of conducting research must be honored and respected without exception. Counselors are responsible for the participant's physical, emotional, and social welfare (ACA, 2014). Throughout this study, the researcher was conscious of these principles. Before initiating contact with potential participants, approval was obtained from the IRB of Liberty University. Each participant was provided an information sheet

that outlined the voluntary nature of the study, as well as confidentiality of participants' private health information. Participants were informed that they could decline participation in the research or at any time after being selected for the study without negative consequences. Study participants were notified of the emotional nature of the study. Any identifying information such as the participant's name, city where they live, personal doctor's name or practice, and other entities mentioned during an interview were changed to protect the participant's privacy.

Summary

The preceding sections discussed the history, rationale, and procedures for the research design selected for this study. RQs, participant selection, researcher's role, trustworthiness, and ethical considerations were also discussed. This study is a qualitative phenomenological transcendental design based on the works of Husserl, Moustakas, and Giorgi, among others, to learn the lived experiences of PM Christian women. Few qualitative studies have been conducted concerning this population or phenomenon. The procedures used in this study were outlined in Moustakas (1994) and include methods of preparation, data collection, organization and analysis of data, and synthesis of meanings and essences. Purposive, criterion-based, and convenience sampling were employed for participant sample selection. Data were collected via personal interviews with each participant over a HIPAA-compliant video conference platform (Zoom for Healthcare) to ensure the privacy and confidentiality of each participant. To minimize bias, the researcher kept a research journal to record any personal feelings or beliefs that may taint the interpretations of the data. Following the individual interviews, the researcher transcribed, re-read, and used a qualitative design software program to analyze the data. The interview transcriptions were reviewed and approved by each participant for accuracy. The study allowed to describe and discuss their experiences to offer a greater understanding to those who live, love,

and work with PM Christian women so that compassion, hope, understanding, and validation can be provided to this population.

CHAPTER FOUR: FINDINGS

Overview

The following chapter features the findings of this study on the lived experiences of PM Christian women. The central RQ was "How would PM Christian women describe their physical, psychological, mental, emotional, relational, and R/S lived experiences?" Other RQs guiding this study include "How do participants describe their physical health during PM?," "How do participants describe their mental health during PM?," "What were the social/sexual experiences of PM Christian women?," and "What did PM Christian women experience in their R/S life?" The conceptual framework for this study is modeled after the bio-psycho-social-spiritual model to fully capture the lived experiences of the participants, which allows for a more holistic approach to treat clients/patients as each aspect of the model is interconnected with the next to make up the whole person, thus adding the human element to the scientific domain (Engel, 1997; Porter, 2020; Saad et al., 2017). With the addition of R/S into the traditional bio-psycho-social model, clinicians can have a better understanding of the whole person; therefore, treatment planning can be a better fit for the client, leading to better quality of life for the client (Koenig, 2012; Saad et al., 2017). Feminist theory also guided the study to magnify the conversation, seek and produce solutions, and bring awareness of the physical, biological, psychological, mental, emotional, social, relational, and R/S needs of PM Christian women (Arinder, 2020; Brabeck & Brown, 1997).

The following sections of this chapter will present the findings derived from the personal interviews conducted with each participant. A description of the setting, the participant sample (no specific identifying information is provided), data collection and analysis process, and themes identified are discussed. Through the raw data gathered, significant themes were revealed

from the coded and collected descriptions of the participants' lived experiences. Lastly, this chapter closes with how RQs were addressed, theme development, and concluding summary of the chapter.

Setting

This phenomenological qualitative study considered the lived experiences of PM Christian women. The participants for this study were personal associates of the researcher (two participants), referred by personal associates of the researcher (two participants), and solicited from Facebook (six participants) and unknown to the researcher. The personal virtual interviews took place over a 1-week period in February 2024 on Zoom for Healthcare, a HIPPA compliant teleconference platform, to ensure the confidentiality of each participant. Confidentiality was discussed with each participant, and assurances were made that no identifying personal information would be used in the final presentation of the study. Each participant was given a pseudonym rather than being identified by their actual name. The participants selected for this study and the interview setting provided an appropriate population of PM Christian women and offered participants a safe, comfortable, neutral atmosphere for participants to discuss their experiences liberally.

Participants

Initially, over 150 individuals responded to the recruitment flyer (Appendix C) posted publicly on the researcher's personal Facebook page and completed the screening questionnaire. Additionally, over 30 individuals responded via email to the researcher inquiring about participation. It was determined that these were either bot-generated responses, or respondents did not meet criteria for study participation (e.g., male gender, outside of age range). In the final sample, 10 Christian women (aged 35-54) provided their personal insights and stories on their

lived experiences in PM. The narratives gathered provided the data presented for this study. In this section, similarities between participants will be identified as well as individual descriptions of each participant, including what set them apart from other study participants. While every effort was made to bracket the researcher's personal assumptions and beliefs concerning the phenomenon being investigated, objectivity was at times difficult to maintain; however, a research journal was kept by the researcher to note their subjective perspectives throughout the progression of the research process.

Participant Demographics

Seventeen potential participants completed the screening questionnaire (Appendix D) on Google Forms and met criteria for participation in the study. Twelve of the 17 potential participants scheduled virtual interviews; however, two individuals did not attend the virtual interview and did not reschedule the interview; therefore, data collected in the screening questionnaire was excluded from the overall findings of the study. Virtual interviews took place via Zoom for Healthcare in February 2024 from South Central Texas.

There were several commonalities among the participants outside of the study criteria. Study criteria included diagnosis of PM or presence of PM symptoms, aged 35-60, assigned female at birth, and identified as a Christian. Most of the participants resided in the United States, whereas one participant (Karen) resided in Canada. All participants had a high school diploma, high school equivalency, or higher education. The following table highlights participant demographics characteristics and mental health diagnoses.

Table 3

Participant Demographics and Mental Health Diagnoses

Participant	Age	Race	Marital status	Mental health diagnosis	Education	Location
Ann	52	White	Married	Anxiety/ADHD*	High school	Texas
Ariane	52	White	Married	PTSD	Masters	Pennsylvania
Eliza	52	White	Married	N/A	Masters	Texas
Gabrielle	40	Hispanic	Married	Depression*/Anxiety*	Bachelors	California
Holly	36	Hispanic	Married	N/A	Bachelors	California
Karen	35	Black	Married	Depression*	High school	Canada
Nicole	42	Black	Single	Depression*/Anxiety*	GED	California
Regina	37	Black	Married	Depression*/Anxiety*	Bachelors	California
Sabrina	54	White	Married	Anxiety	Masters	Ohio
Susy	55	Black	Single	Depression*/Anxiety*	Bachelors	Virginia

Note. *Undiagnosed

Similarities in PM symptomatology, collected from the Data Collection Questionnaire (Appendix E) include biological and physical symptoms reported such as headaches (eight), hot flushes (eight), insomnia (six), irregular menstrual cycles (seven), metabolic irregularities (seven), night sweats (10), random aches and pains (seven), sexual dysfunction (six), and weight gain (see Table 4). Psychological, mental, emotional, and cognitive symptoms reported consist of anxiety (eight); cognitive deficits such as “brain fog,” confusion, and forgetfulness (nine); depression (five); emotional instability (six); hostility (two); and irregular mood (six). More than half of the participants reported the presence of or diagnosis of a mental health disorder prior to PM or concurrent to PM. Three participants (Ann, Ariane, Sabrina) reported a mental health diagnosis (i.e., anxiety, PTSD) prior to PM, whereas five participants (Gabrielle, Karen, Nicole, Regina, Susy) reported the presence of symptoms of a mental health disorder but were not officially data collection questionnaire diagnosed with a mental health disorder. Social and relational issues reportedly experienced during PM involved adverse life events (e.g., death of a parent or loved one), employment issues (i.e., job loss), financial issues (e.g., due to “COVID”), and relationship difficulties (i.e., in relation to “sexual dysfunction”). The following table

highlights the participants' PM symptomatology.

Table 4

Perimenopausal Symptoms Reported

PM symptom	Ann	Ariane	Eliza	Gabrielle	Holly	Karen	Nicole	Regina	Sabrina	Susy
Adverse life events	•	•			•		•			
Anxiety	•	•		•		•	•	•	•	•
Cognitive deficits	•	•		•	•	•	•	•	•	•
Confusion				•		•				
Depression				•		•	•	•		•
Emotional instability					•	•	•	•	•	•
Employment issues	•						•		•	
Financial issues							•	•		
Forgetfulness	•			•		•	•	•	•	•
Headaches	•	•	•	•	•	•	•	•		
Hostility					•	•				
Hot flushes	•	•	•	•			•	•	•	•
Insomnia				•	•		•	•	•	•
Irregular menstrual cycle	•			•	•		•	•	•	•
Irregular mood				•	•		•	•	•	•
Metabolic irregularities	•	•		•	•		•	•	•	
Night sweats	•	•	•	•	•	•	•	•	•	•
Random aches & pains	•	•		•		•	•	•	•	
Relationship difficulties	•	•			•	•				•
Sexual dysfunction				•	•	•	•	•		•
Weight gain	•	•		•		•	•	•	•	

At the beginning of each interview, each participant was reinformed that the interview would be recorded and permission to record the interview was obtained. The participants were reminded that participation in the study is voluntary and that they could opt-out at any time during the interview if they did not feel comfortable to continue. In each interview, participants were informed that the role of the researcher was to gather information, not to act as a counselor, friend, or fellow sister in PM. The researcher explained the process of the interview: a data collection survey would be utilized to gather more specific symptoms of PM first, and then the researcher would go into the interview questions. Finally, a test of the recording equipment was conducted, and the interview commenced. Upon completion of the interview transcriptions, each participant was emailed a copy of their interview transcription to ensure accuracy. Minor issues were noted within some of the transcriptions (i.e., errors related to the transcription software);

however, no issues were noted with regard to the content of the transcriptions. The following section includes a more detailed depiction of each participant and their story. No personal identifying information is disclosed, and pseudonyms were used for each participant.

Participant Stories

This section highlights the stories of each participant and their journey as a PM Christian woman, thus far, based on information gathered through the screening and data questionnaires and personal virtual interview. Each participant is listed alphabetically by their pseudonym and no personal identifying information is disclosed for the privacy of the participants.

Ann

Ann is a 52-year-old White female, is married, and lives in Texas. She identifies herself as a wife, mother, grandmother, sister, aunt, church member, and employee. She has a high school education. Ann is employed; however, she does not seem satisfied in her current occupational role as "I'm not appreciated for the workload that I'm doing." Ann expressed she has a loving husband but felt that he could be more open when it comes to the discussion of PM; however, she stated "my husband's a big key part" of her overall support system.

Ann reported she has experienced many of the specific symptoms listed on the Data Collection Questionnaire (Appendix E) to include the experience of adverse life events during PM, anxiety, cognitive deficits, employment issues, forgetfulness, headaches, hot flushes, irregular menstrual cycles, metabolic irregularities, night sweats, random aches and pains, relationship difficulties, and weight gain. Ann indicated PM has "definitely impacted my life" and has rated her overall PM experience at an 8. Significant factors that contributed to her overall experience include irregular menstrual cycles, menorrhagia (i.e., excessive bleeding or cycle lasting more than 7 days), increased emotionality (i.e., crying for little to no reason),

changes in social planning, and R/S growth.

Ann mentioned that she has many elder female friends she leans on for support; however, when it came to the topic of PM, many of her friends were unable to provide her feedback on their experiences as they have had hysterectomies or did not know what they had experienced was PM. Another contributing factor to Ann's overall PM experience pertains to planning social events on her calendar. Due to her irregular menstrual cycles and social anxiety, Ann stated "I'm not reliable on my calendar" as she cannot rely on a 28-day cycle anymore. Ann stated she has "had anxiety even as a little girl;" however, "I do find myself more emotional than I have ever been in my life."

Ann reported "my faith is strong" and "I'm relying on God and His guidance" on her PM journey to health and healing. Ann revealed that much of the time she would see her physicians; the recommendation was to take pills. Ann has opted to approach her journey through PM in a natural way through the help of a naturopath doctor, vitamins, and natural remedies. She expressed that she works closely with her doctor and does her own research to make well-informed decisions about her care. Ann stated, "I know that God put these things [plants] on Earth … and so it's really made me look for the natural products for a reason."

Ariane

Ariane is a 52-year-old White female, is married, and lives in Pennsylvania. Ariane holds a master's degree and expresses that she loves what she is able to do in her work. She identifies herself as a wife, "mom with five kids," friend, daughter, daughter-in-law, sister, sister-in-law, student, church member, and caregiver. Ariane stated she recognizes that the roles she has played in life are evolving:

I'm no longer that young mom, you know? I'm now kind of transitioning, obviously,

> potentially becoming a grandmother within the next year … seeing a change in the stage of life of not just the reproductive cycle, but even like my identity. Where I fit in those stages, maybe. Yeah, yeah. Definitely … the transition between being a mom with kids at home versus being a mom of adult kids.

Ariane reflected on how these changes in her roles have affected her life, "maybe just having a little more freedom to invest in myself."

Ariane reported she has experienced many of the specific symptoms listed on the Data Collection Questionnaire (Appendix E) to include the experience of adverse life events during PM, anxiety, cognitive deficits, headaches, hot flushes, metabolic irregularities, night sweats, random aches and pains, relationship difficulties, and weight gain. Ariane reported she has been experiencing symptoms of PM for about a year to 18 months but has not seen a physician specifically for PM: "I haven't actually spoke with the physician about it. It's just more kind of my own journey to figuring out what the heck is going on with me." Ariane reported she has noticed a significant increase in headaches along with waking up in the middle of the night with random aches and pains (e.g., knee, hand, shoulder, hip), "which was not something in my 40s." She expressed she has gained some weight and has also noticed she has lost some flexibility, which means she has to be intentional about her physical activity; however, she notes, "I used to just be able to go out and do whatever I wanted, and now I work for an afternoon, and my body is like, what are you thinking? You're silly!"

Ariane reported her psychological, mental, and emotional health has improved since discovering she has PM symptoms, "I kind of feel like I'm doing better now than I was before … I would say it's improved … the instability and the irritability is just, it's just not there anymore." Ariane contributed, "being intentional to do the things that lead to more peace and

calm" to her improved mood. For Ariane, staying on top of her headaches, walking her dog or walking on the treadmill, spending time in the hot tub, and sleep are priorities.

Ariane reported that she and her husband "have a good network of friends at church, and then, through [school], obviously got some great new friends that are also struggling along in the program. So, they've been a definite source of support." She reflected on the shift in her role as a mom of teens to a mom of adult kids:

> I actually have my own social life, and I'm not just Paul or Holly's mom, or whatever. Now I'm [Ariane], and I have my own circle of friends that are not friends because well, I mean, I still have friends that are friends because of our kids, but I kind of feel like they're my own friends now. We have friends that literally aren't because of our kids, which is like a new stage of life.

Following the births of her two biological children and traumatic loss of two pregnancies, Ariane and her husband made the "decision not to try for pregnancy anymore." She went on to say that she questioned whether that was the right decision as she wanted a big family; however, "I was also scared and traumatized from losing the first one" due to an ectopic pregnancy, "and then the second one, the baby had a genetic defect." Ariane described how she was given the option to abort but carried her baby for 5 months before the baby passed. Ariane shared, "did I choose the right thing … spiritually. Is this something that I did, that God didn't want me to do? Was it my will or was it His?" Ariane continued, "that was something I definitely struggled with." She expressed that she knows there is nothing that can be done now that she is in PM, and that "God's gonna use whatever choices I made to do what's good." Ariane explained that she copes through prayer, and "I think just being at peace with my ridiculously crazy life and knowing that God's got to be having something bigger in mind than what I am aware of, because

it has just been so crazy. Working towards opening my hands to whatever God has for me."

Eliza

Eliza is a 52-year-old White female, is married, and lives in Texas. Eliza identifies herself as a wife, mom, daughter, business owner, "member of the adult gymnastics class," and "friend, definitely friend, I have a good number of friends." She holds a master's degree and carries state licensure for her profession. Eliza shared that she was "surprised" when she was initially informed by her OB/GYN that she was in PM:

> I guess it just didn't really enter my mind but actually hearing the doctor say that at the last appointment I was kind of not prepared for that. I was a little bit surprised and needed a few days to kind of process it and talk with friends and just kind of work my mind around it. When I think about it now, I'm sure it would be highly likely I would. I've been in PM probably long before she ever said anything but just hearing it was a bit of a shock for me … I think in some weird, strange way, I wore this idea of I'm not gonna start menopause, or you know, premenopause, or whatever till I'm like, really old.

Eliza expressed it was "the idea of aging" that bothered her, "almost like this pride thing." She admitted that the knowledge of being in PM has been "challenging, and it's humbling, and it keeps me in check, I guess." Eliza has since shared that once the initial shock wore off and she had time to process this information with her husband and female friends that, "I've worked my mind around it now, and it's very reasonable. It makes sense."

Eliza reported she has experienced a few of the specific symptoms listed on the Data Collection Questionnaire (Appendix E) to include headaches, hot flushes, and night sweats. Eliza's overall PM experience was 3. She expressed that she was not aware that she had any symptoms that indicated she was in PM. Eliza reported she is on hormonal birth control and

when “I’m not taking the pill and the hormone levels drop, I’m really not experiencing symptoms except for a little bit of the hot flush that week.” She stated that now that she knows she is in PM, this has “increased the importance, to me, to feel like I really need to do weight bearing exercise … [to] increase the density in my bones” to avoid “osteopenia or osteoporosis.” Eliza explained that the knowledge of her in PM has affected how she takes care of her body now.

Gabrielle

Gabrielle is a 40-year-old Hispanic female and lives in California. She identifies herself as a wife, mother, and daughter. She holds a bachelor’s degree and is a caregiver by profession. Gabrielle reported she has experienced many of the specific symptoms listed on the Data Collection Questionnaire (Appendix E) to include anxiety, cognitive deficits, confusion, depression, forgetfulness, headaches, hot flushes, insomnia, irregular menstrual cycles, irregular mood, metabolic irregularities, night sweats, random aches and pains, sexual dysfunction, and weight gain. Gabrielle shared that PM has affected her “in a negative way, because I can no longer do things I used to do.”

Gabrielle expressed that her irregular menstrual cycles in PM “depresses me literally … I feel low on myself, like I feel I’m old. I’m getting old.” Gabrielle shared that she feels “weak, so I no longer do things I used to do before … I’m just inside … keeping myself away from people.” Gabrielle reported that her physician recommended she try to attend social gatherings with her friends, to which she stated, “sometimes I’ll make a move to go out, interact. Yeah, but not all times.” Despite “self-isolating,” Gabrielle mentioned that her support system is “good.”

Holly

Holly is a 36-year-old Hispanic female, is married, employed, holds a bachelor’s degree,

and lives in California. Holly identifies herself as a mother, employee, wife, and a spiritual woman. Holly reported she has experienced many of the specific symptoms listed on the Data Collection Questionnaire (Appendix E) to include the experience of adverse life events during PM, cognitive deficits, emotional instability, headaches, hostility, insomnia, irregular menstrual cycles, metabolic irregularities, night sweats, relationship difficulties, and sexual dysfunction. Holly shared, "I'm experiencing changes in my body," and stated that PM has affected her physically and emotionally. Holly reported the biggest changes have occurred with her menstrual cycle, her sexual drive, and emotions, which has carried over into her relationship with her husband:

> Sometimes we may fight, or because of changes emotionally … but we come to terms later, and understand that there are changes in life in a woman, there are changes emotionally … There are things you do in marriage; he has now come to understand that there are changes and he accepts that.

As previously mentioned, Holly identifies herself as a "spiritual woman." She expressed her R/S life has been "really affected" because of PM. She described her R/S life before PM and how PM has negatively affected her engagement in spiritual practices:

> I used to pray as usual. I used to engage in my spiritual study groups. It [PM] really affected me, because sometimes I couldn't manage to go to spiritual study groups. Sometimes I forget then to pray because I have difficulty in concentration … Attending to services, it has changed. Yeah, that has really changed. At times, you wake up, maybe not feeling it, having your mood changes. So, it has really affected my spiritual life.

Holly shared that when she is feeling down she will read scripture to improve her mood. She expressed that she tries to pray, engage in devotions, and attend spiritual study groups: "it has

affected me, but I really try a lot to engage in my spiritual life."

Karen

Karen is a 35-year-old Black female, is married, lives in Canada, and has a high school education. She identifies herself as a wife and a caregiver. Karen reported she has experienced many of the specific symptoms listed on the Data Collection Questionnaire (Appendix E) to include the anxiety, cognitive deficits, confusion, depression, emotional instability, forgetfulness, headaches, hostility, night sweats, random aches and pains, relationship difficulties, sexual dysfunction, and weight gain. Karen shared that she "feels depressed, emotional, and a lot more negative" when she thinks about PM. She expressed that she has experienced an "emotional dump … overthinking … loss of memory sometimes." Additionally, she reported that "sometimes I feel rejected among the people around me and in relationship with people."

Nicole

Nicole is a 42-year-old Black female, is unmarried, and lives in California. Nicole identifies herself as a Christian, "a secretary," a daughter, friend, employee, and an usher in her church. She has her high school equivalency and is currently employed as a secretary. Nicole is one of two participants who are unmarried, and she expressed PM has affected who she is looking for in a life partner: "I had to change my social standards. I had to change whatever I was looking for relationship wise. I started looking out for men who were not interested in kids … So, I had to change whatever I was looking at."

Nicole reported that PM has affected her life "mostly negatively." Nicole reported she has experienced many of the specific symptoms listed on the Data Collection Questionnaire (Appendix E) to include the experience of adverse life events during PM, anxiety, cognitive deficits, depression, emotional instability, employment issues, financial issues, forgetfulness,

headaches, hot flushes, insomnia, irregular menstrual cycles, irregular mood, metabolic irregularities, night sweats, random aches and pains, sexual dysfunction, and weight gain. Nicole's overall PM experience was rated at an 8. Significant biological factors that contributed to her overall PM experience include decreased libido, vaginal dryness, hot flushes, low energy, and weight gain. Nicole stated:

> I was a person who couldn't go three or four days without having sex, but I can last almost two months or three months without feeling that urge. So, you know, I've been fighting with myself, with my thoughts as I keep asking myself if everything's okay, you know? Why all the sudden change of the sex urge?

Nicole went on the elaborate on the changes that have occurred in her eating habits and resulting weight gain, "I just eat about everything, you know. I don't pay attention to my weight like I used to do just to have a sexy, gorgeous body." Additionally, significant psychological factors Nicole reported she noticed were getting "irritated very quickly, emotions could shift from being happy to being rude and sad in a few minutes."

She noted that her "social support has been okay" and that "I'm actually the one who has been pushing them away." She expressed her friends try to take her out for "social functions or just outings to have a good time, but most of the time I end up ruining it by wanting to go back to my safe place, my home that is." She reported there has been a "drastic" change in her going out with friends, "and also I just don't deal with people like the way I used to deal with people … I have been a bad friend since PM … My friends are really complaining that I've changed a lot socially."

Nicole shared that due to the effects of PM on her physical, mental, and social health, she "really took my time just to get to know the Bible, just to read and understand the Bible, like

move in closer to God." Because of her efforts to learn more about God, she has seen an improvement in her spiritual health. "It [PM] has improved how I take care of my spiritual and religious life, me getting closer to God, and also having the opportunity to be an usher in my own church. You know it was improvement on my side."

Regina

Regina is a 37-year-old Black female who lives in California. Regina identifies, "I'm a Christian by birth." Regina did not share any information about the roles she plays in her life: "I don't have an answer to this one, it's a bit hard." Regina reported that she has experienced many of the specific symptoms listed on the Data Collection Questionnaire (Appendix E) to include the anxiety, cognitive deficits, depression, emotional instability, financial issues, forgetfulness, headaches, hot flushes, insomnia, irregular menstrual cycles, irregular mood, metabolic irregularities, night sweats, random aches and pains, sexual dysfunction, and weight gain. Significant factors that have contributed to her overall PM experience include "abnormal menstrual flow and then the heat splash … and depression for about a period of like, roughly two to three years … I added weight … my breast was no longer firm." Regina also expressed that there were times she was too tired to pray due to PM, which bothered her greatly. Recommendations Regina's physician suggested, "reduce the level of stress, I should reduce the workload like I shouldn't be involved in stressful jobs … and then I should exercise." Regina reported that she has engaged in more exercise to help reduce her symptoms.

Sabrina

Sabrina is a 54-year-old White female, is married, and lives in Ohio. She identifies herself as a wife ("that's my primary relationship"), "mom, but I'm an empty nester mom," "grandma, okay, I love that, I love my little guys," "dog mom, that's important," and "company

owner, which is a big shift." Sabrina holds a master's degree and recently became a business owner: "instead of working for somebody else, that's probably the biggest change." She expressed that in her previous work environment she felt "less appreciated" and "realized that I did not need to be an employee there."

Sabrina reported that she has experienced many of the specific symptoms listed on the Data Collection Questionnaire (Appendix E) to include the experience of anxiety, cognitive deficits, emotional instability, employment issues, forgetfulness, hot flushes, insomnia, irregular menstrual cycles, irregular mood, metabolic irregularities, night sweats, random aches and pains, and weight gain. Sabrina shared, PM has impacted assumptions about herself with regard to her cognitive functioning: "there's definitely some self-doubt there, especially with the brain fog, not being able to absorb things as quickly as I used to, having to reread things. I know that I'm intelligent and capable, but sometimes I question it."

Sabrina reported that she had some knowledge about PM and believed she knew what was happening to her; however, she did not want PM to begin as it did have an effect on her functioning:

> I already knew a lot about it [PM], so I could tell when the symptoms were starting, it was more frequent … waking up and not going back to sleep and feeling achy and starting to gain weight. That was kind of frustrating because I tend to always be on the go and to be tired like that, it was like, I knew it was coming, but I didn't want it to. I wanted to be able to be myself and to have the energy to keep being that driven person that I had been.

Significant biological factors that have contributed to her overall PM experience include increased intensity of hot flushes and night sweats, inability to go back to sleep, increased "brain

fog," increased weight gain ("that's been more of a challenge"), and irregular menstrual cycles ("I went for about 10 months with no period. I thought I was moving to menopause and then they came back which was very disappointing and frustrating").

Sabrina reported significant psychological factors that have contributed to her overall PM experience include increased anxious mood and irritation. Her approach to manage her mental health is aided by her awareness of what is happening in her body:

> I think I am more aware of them [my reactions to stressors] as just being kind of a natural reaction to the hormonal changes that are, well I may not have control of them happening, I do have control of how I respond to them [stressors] … what's happened today that makes me feel this way rather than I'm just irritated today.

Sabrina continued that she is more intentional about how she takes care of herself, "realizing that I need to save space for myself, that I need to take breaks, that it's okay to sit and have a piece of dark chocolate when feeling a little down but I don't need to eat the whole bag." She expressed that she has made herself the priority rather than "always being on the go for everyone else."

Susy

Susy is a 35-year-old Black female, is unmarried, and lives in Virginia. She identifies herself as a daughter, sister, nanny, friend, and a high school chemistry teacher. Susy is the youngest participant in this study. When asked what comes to mind when she hears the word PM, she stated "the first thing that comes to mind is menopause, and it was very scary for me." Susy is also one of two participants who are unmarried, and she expressed how PM has affected her and her vision of the future:

> I've not settled with anyone. I still want to have kids in the future. It [PM] takes away from me the hope of having kids. I had a clear vision of my future, like me, my kids, my

> husband, but right now, no, it's not there anymore … I have a friend. She recently told me that she is pregnant. I was hard because that's the life I envisioned for myself.

Susy reported she has experienced many of the specific symptoms listed on the Data Collection Questionnaire (Appendix E) to include the anxiety, cognitive deficits, depression, emotional instability, forgetfulness, headaches, hot flushes, insomnia, irregular menstrual cycles, irregular mood, night sweats, relationship difficulties, and sexual dysfunction. Susy stated she consulted with several physicians with the last physician ordering a blood draw that revealed her hormone levels had dropped. She expressed she has experienced "a lot of anxiety" since she was informed she was in PM, and she has started seeing a therapist. Additionally, Susy mentioned she has been conscious about her food choices and is watching what she eats.

Due to PM's occurrence at 35 years of age, Susy shared that PM has her:

> Questioning a lot of things because of how I was brought up. I was brought up in a Christian household, and we were taught that you're supposed to keep yourself for who you marry. I'm questioning that because why is this happening to me right now? I'm supposed to be getting married.

Susy expressed that, "I still believe in God," and she wished she "could find something like [a support group in the church] that helps women … I could have a safe space." She explained that it is hard for her to talk to anyone about what she is going through and feels they would not understand because of her age.

Throughout the interviews, each participant was asked to rate their bio-psycho-social-spiritual and overall PM experience on a scale from 1-10, 1 being no affect and 10 being very affected by their PM symptoms. Findings suggested biological, physical, psychological, mental, emotional, and cognitive symptoms impacted participants the most. All participants expressed a

strong relationship with God; however, for some participants (Ann, Nicole, Regina, Susy), their walk with God had been affected due to their experience with PM. The following table highlights participants' ratings of their bio-psycho-social-spiritual and overall PM experience.

Table 5

Effect of Perimenopause on Bio-Psycho-Social-Spiritual Well-Being

Participant	Biological	Psychological	Social	Spiritual	Overall
Ann	10	6.5	5	10	8
Ariane	4	3	4	3	4
Eliza	1.5	5	3	1	3
Gabrielle	7	7	5	1	5
Holly	6	6.5	5	5	6
Karen	6	7	6	1	5
Nicole	7	8	9	9	8
Regina	5	8	1	6	5
Sabrina	6.5	4	6	5	5
Susy	6.5	8	6	8	7

Note. Rated using a Likert scale (1 = *no effect*, 10 = *very affected*)

Group Narrative

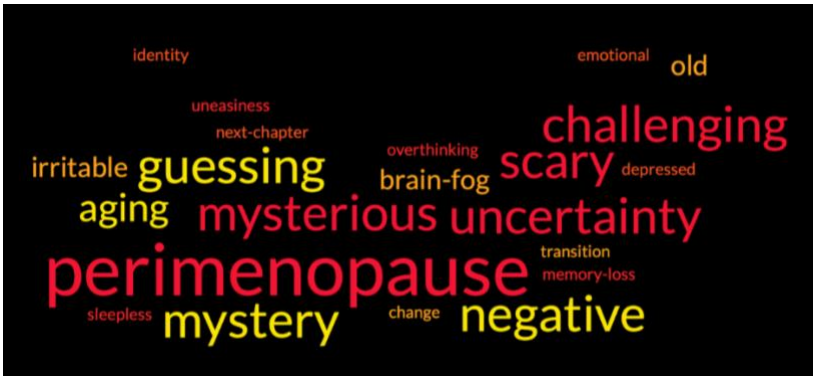
The purpose of this section is to share what the participants collectively conveyed about what they would like to have known before PM and what they feel would prepare women for the PM experience. In Part IV of the interview questions, participants were asked two questions: "What would you like to have known before entering PM?" and "What changes could be made, based on your own experience, to better prepare women for what they will experience during PM?" Similar answers were given for each of these questions. For Question 1, Ann stated, "I wish I knew what PM was before I knew what PM was … I wish I knew more." Karen made a similar statement: "I wish I have had more enlightenment about it before now." Regina concurred in her comment, "I would have liked to know more about detailed symptoms." Lastly, Sabrina expressed, "I think I can sum all of it up with knowledge is power."

Words and phrases such as, "I didn't even know what the signs were" and "I thought you

had them [period] one day and then you didn't the next" (Ann), "mysterious," "challenging", and "not really being certain where PM stops and menopause starts and the hormones are not gonna do their thing anymore, so I'm guessing" (Ariane), "mystery" (Eliza), "negative" (Karen and Nicole), and "scary" (Susy) were used to describe their first thoughts when they hear the word "PM." Based on the data gathered, ambiguity and apprehension seemed to be the general first impression to the word "PM," which makes sense when the journey is commenced and the passenger does not know where they are going or what they are doing on the journey. In contrast to ambiguity and apprehension, Ariane expressed feeling, "a mixture between relief, like I'm done with that part of my life," and Sabrina shared, "some of it [PM] is easier, less periods, that's kind of nice." The following figure is a Word Cloud representation participant's first thoughts hearing the word PM.

Figure 3

Participants' First Thoughts Hearing the Word Perimenopause



For Question 2, participants had many suggestions on how to better prepare women for what they will experience during PM. Ann stated:

> Women should not be afraid to talk about these things, they [PM] should not be taboo to talk about … it [PM] needs to be a conversation that men and women need to have … an open line of communication … not just for women, but for men. You know that we

understand that our bodies are changing.

Ariane reported, “making it [PM] more of a conversation, you know, people just don’t talk about it, so we are kind of blindsided because it feels like the topic is skirted and not really addressed” and expressed “women should be informed of what they can expect in PM or what to look for, especially all the weird body aches.” Eliza shared that she would like to have known the “actual biological mechanics, like understand it better because [PM] was a little bit of a mystery,” and suggested doctors could broach the subject of PM with their female patients during their annual checkup “which women are going to do well before PM, just so they know what is coming up.” Eliza also suggested, at that time, patients could have their questions addressed, better understand what PM means, what to expect during PM, and learn about potential symptoms.

Gabrielle proposed having meetings for women to open up the conversation and receive education about PM and what to expect, especially because, “it’s [PM’s] not always the easiest conversation … to get this discussion going and bring to light where it’s not some taboo subject that we don’t talk about.” Holly, one of the younger participants in the study, recommended “so in my case, I feel that there should be a way of creating awareness in women by engaging them in how PM is, the symptoms, and how they should conquer that even in their social and spiritual life at that age.” Karen simply shared one word, “awareness.” Nicole had a similar perspective to Eliza in that she felt women should be “educated about PM even before they get to that stage, so they know what to expect of it and be aware”, she also added, “women need to get enough sleep, manage daily stress, be self-aware, don’t let them [stress] manage you.” Regina had similar thoughts about bringing awareness and educating women on PM, “maybe online classes to educate people on what to expect.” Sabrina shared her thoughts, “knowing that there are ways to take care of it [PM] and you don’t have to just suffer”, and suggested printing information for

women to know about potential symptoms, and "that it's [PM] not a death sentence." Sabrina continued, "we've learned so much in the last 20 years about PM and menopause that we can't look at it the way we did. The way our mothers did. It's a different time … so you can pursue a healthy approach and that it doesn't have to take over your life." Lastly, Susy shared that, "this [PM] information should be out there because there isn't much information out there [on PM]." The following figure is a word cloud of participants' recommendations to better prepare women for PM.

Figure 4

Participants' Recommendations to Prepare Women for Perimenopause

At this point, it is important to note, specific data such as socio-economic status, marital status, sexual orientation, living environment, occupation, other medical conditions, medication use, or recreational drug use can affect a woman's experience during PM. Nevertheless, the impact of those variables on a participant's PM experience were not included in this study and their exclusion are further discussed in Chapter 5. Based on the data collected for this study on the lived experiences of PM Christian women, the themes and subthemes that emerged from the data are discussed in the following section.

Findings

The Central RQ asked for this study was "How would PM Christian women describe

their physical, psychological, mental, emotional, relational, and R/S lived experiences?" Participant feedback to the interview questions revealed three primary themes: I Don't Understand What is Happening to Me, Why Do I Feel this Way All of a Sudden? I Wish I Knew More Before PM: Opening Up the Conversation, and There is a Light at the End of the Tunnel: Positive Coping. The themes that emerged connected all four RQs; however, the second theme that emerged provided recommendations and suggestions to destigmatize the conversation, and increase communication, about PM, and the third theme addressed coping skills and protective factors. Additionally, several subthemes developed for each primary theme. Subthemes that emerged for Primary Theme 1 include The Change is For Real: Bio-Psycho-Social-Spiritual Changes in PM, Who Am I?: Self-Identity in PM, and Leave Me Alone: Self-Isolation in PM. Subthemes that emerged for Primary Theme 2 include PM is More Than Just Hot Flushes: Expectations, We Need to Talk: Communication, Education, and Awareness, and Destigmatizing PM: It Is No Longer a Taboo Subject.

Theme Development

Subsequent to the data collection, the raw data are prepared for analysis. The focus of the analysis is the emergence of distinctive and integrative descriptions. These descriptions are constructed from all the participant reported experiences specifically related to the phenomenon and then synthesized into meanings and essences. Specific characteristics of the experience are highlighted; nevertheless, the challenge for the researcher to accurately interpret the meaning of the phenomenon in a way those who have experienced the phenomenon will understand (Moustakas, 1994; Peoples, 2021).

Transcripts of each virtual interview were generated, re-read by the researcher, uploaded to Delve to identify repetitive words and phrases, and coded. Codes were words or phrases that

embodied the distinctive features of the data collected (Peoples, 2021). Coding the transcript consisted of reviewing and sorting (when appropriate) each line of the transcript into different groups (codes). New codes were added as the researcher read through each transcript. Once all of the transcripts were reviewed and initial codes established, the researcher reviewed the outline of codes that emerged from the raw data, determined which codes were similar, and merged those codes together (where appropriate); brief descriptions were added to each code to explain the meaning of the code, and primary themes and subthemes were then identified (Delve, 2024).

Any potential for researcher bias during the development of the codes was documented in the research journal. The code outline evolved through the analysis and re-analysis of the data, which yielded primary themes and subthemes. The data collected appeared to concur with current research on the phenomenon being studied. Primary themes and subthemes were connected to the RQs and were incorporated into the data analysis, findings, and researcher interpretation. Primary Theme 1 encompassed the bio-psycho-social-spiritual changes experienced, identity issues, and imposed self-isolation, whereas Primary Theme 3 comprised the need for increased knowledge and discussion on the topic of PM, along with breaking the stigma associated with PM. Primary Theme 3 focused on positive coping. The following sections will discuss the three primary themes that emerged from the data analysis.

Primary Theme 1: I Don't Understand What is Happening to Me, Why Do I Feel this Way All of a Sudden?

As mentioned, there is a limited amount of literature focused on women's mental health and lived experiences during midlife, specifically during the years of PM. But PM is a global health issue that carries, for many women, medical and psychological side effects that, if left untreated, can lead to a significant deterioration in quality of life (Frey et al., 2013; Hunt, 2016;

Jafari et al., 2014; Muharam et al., 2018; Onder & Batigun, 2016; Sandilyan & Dening, 2011; Sharma & Mahajan, 2015; Shokri-Ghadikolaei et al., 2022). For PM Christian women, there is a lot of ambiguity and apprehension due to a variety of factors such as inconsistencies in the information provided (i.e., stages of MP, length of time, ages, expectations, symptoms involved), uninformed about PM (due to a lack of resources), shame or embarrassment, guilt, stigma, or had previous bad experience with a medical professional (e.g., misdiagnosed, feeling ignored or brushed off, misinformed), among other reasons. Therefore, they do not understand what is happening with their bodies. Primary Theme 1 incorporated the bio-psycho-social-spiritual changes experienced by PM Christian women in this study, identity issues faced, and imposed self-isolation.

Subtheme 1.1: The Change *is* for Real: Bio-Psycho-Social-Spiritual Changes in PM.

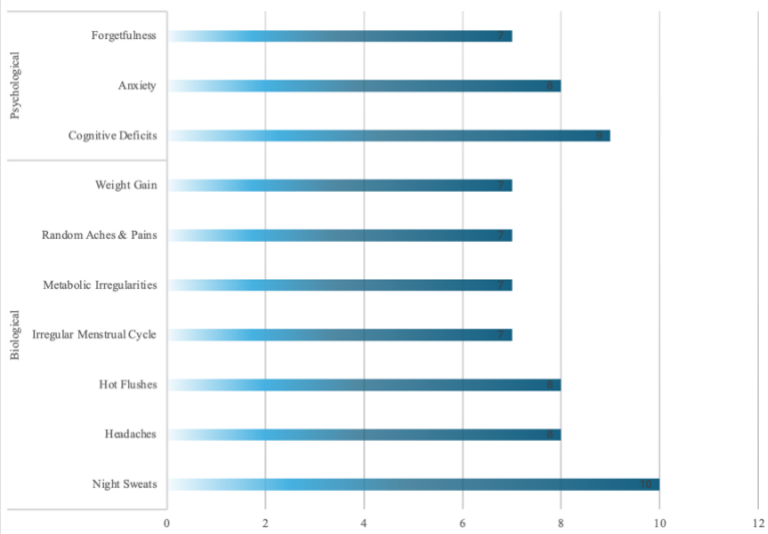
"The Change *is* For Real" is a satirical play on words that took the antiquated phrase "the change," used to describe when a woman was about to go into menopause, to emphasize that PM is real and carries real symptoms and concerns for those affected. In this section, the bio-psycho-social-spiritual changes participants experienced are discussed and compared to the research. Based on the research, common physical health symptoms experienced during this stage of menopause include insomnia, irregular menstrual cycles, night sweats, hot flushes, sexual dysfunction, metabolic irregularities, headaches, weight gain, and random aches and pains (Delamater & Santoro, 2018; Elavsky, & McAuley, 2007; Frey et al., 2013; Gibbs et al., 2013; Hunt, 2016; Levin, 2015; Mauas et al., 2014; Pagán, 2018; Sandilyan & Dening, 2011; Terauchi et al., 2013; Woods & Mitchell, 2011; Worsley et al., 2014). For the participants of this study, there was no difference in symptomology reported. The top three biological and physical symptoms reported by study participants were night sweats (10 participants); headaches and hot

flushes (eight participants each); and irregular menstrual cycles, metabolic irregularities, random aches and pains, and weight gain (seven participants each).

For many women, inconsistent hormone levels, although a physical symptom, manifests in mood instability and other mental health issues such as emotional instability, irregular mood, depression, anxiety, cognitive deficits, forgetfulness, hostility, and confusion. Furthermore, there is an amplified risk for reoccurrence of, or initial onset of, major depression or anxiety during PM as compared to the other stages of the MP (Becker et al., 2007; Blackmore et al., 2008; Bromberger & Epperson, 2018; Bromberger et al., 2007, 2011; Delamater & Santoro, 2018; Elavsky & McAuley, 2007; Flores-Ramos et al., 2018; Gibbs et al., 2013; Hunt, 2016; Jagtap et al., 2016; Karkhanis & Mathur, 2016; Levin, 2015; Mauas et al., 2014; Pagán, 2018; Pearson, 2010; Sandilyan & Dening, 2011; Terauchi et al., 2013; Woods & Mitchell, 2011; Worsley et al., 2014). The participants of this study reported something slightly different than what previous research claims; however, that will be discussed in Chapter 5 of this study. The top three psychological, mental, emotional, and cognitive symptoms (see Figure 5) reported by study participants were cognitive deficits (nine participants), anxiety (eight participants), and forgetfulness (seven participants). Half of the participants reported they experienced depression in PM.

Figure 5

Top Three Most Prevalent Symptoms Experienced



Each part of the bio-psycho-social-spiritual model makes up the whole person. Quality of life is a balance of biological, psychological, social, and spiritual functioning (Jafary et al., 2011). For many of the participants of this study, their physical and mental health symptoms of PM affect their social and R/S functioning, which affects quality of life. For example, Ann shared that due to irregular menstrual cycles, menorrhagia, severe headaches, and anxiety, she has to carefully plan her schedule. She stated, “that has affected my vacations and that has affected my outings.” Sometimes Ann has to cancel plans, change her plans, limit her activities, or make herself push through on her plans due to physical PM symptoms. Ann expressed, “I’ve learned that I have to plan … I am not reliable on my calendar.” These symptoms have affected Ann’s engagement in R/S activities. Ann shared, “I’m not as active a [church] member anymore.” Ann explained that she was once actively involved in church activities and enjoyed her time at church; however, she has had to cut back on her church involvement. Gabrielle also mentioned that her irregular menstrual cycles and resulting depression have had a negative impact on her social functioning. She shared that she feels “weak, so I no longer do things I used

to do before."

Holly also expressed that due to the physical and emotional changes (i.e., irregular menstrual cycle, decreased libido, and increased emotionality) in her body from PM, she has experienced issues in her social and R/S life. She also reported that there has been some tension in her marriage because of these PM physical and emotional changes: "sometimes we may fight, or because of changes emotionally." She did mention that her husband has been more understanding and accepting as time progressed. Holly also expressed her R/S life has been "really affected" by PM and limited her engagement in R/S practices: "I couldn't manage to go to spiritual study groups. Sometimes I forget then to pray because I have difficulty in concentration … you wake up [to attend services], maybe not feeling it, your mood changes." Holly reported that despite the effect PM has had on her R/S life, she does what she can to make an effort to engage in her spiritual life. Regina shared a similar concern, where due to her PM symptoms, there were many times she was too tired to pray, and this bothered her greatly.

Nicole, one of two study participants who are unmarried, shared that her PM experience has affected her plans for the future such as friendships, marriage, and kids. She stated, "I started looking out for men who were not interested in kids" and continued with "I can say it has changed my perspective on the relationships around me." Nicole went on to share, "my social support has been okay, I am actually the one who has been pushing them away." She reported that her friends will try to take her out, but she will "end up ruining it by wanting to go back to my safe place." Additionally, she also expressed how biological factors such as decreased libido, vaginal dryness, low energy, and weight gain have negatively impacted her sex life: "I was a person who couldn't go three or four days without having sex, but I can last almost two months or three months without feeling that urge … Why all the sudden change of the sex urge?" Due to

all the changes in her physical, psychological, and social health, she has spent more time reading the Bible, understanding the Bible, and "move in closer to God," which has had a positive impact in her spiritual growth and has given her "the opportunity to be an usher in my own church."

Susy, the youngest participant in the study, shared how her PM experience has affected her plans for the future: "It [PM] takes away from me the hope of having kids. I had a clear vision of my future … it's not there anymore." Susy expressed that she had a friend who recently announced that she was pregnant, and that was difficult on her because, "that's the life I envisioned for myself." Susy reported she has consulted with many doctors before being informed she was in PM, which brought "a lot of anxiety." Susy stated she was recommended to see a therapist. Susy shared that her PM diagnosis has her "questioning a lot of things" related to marriage, sexual intimacy, and children. She reported that through her Christian upbringing, "we were taught that you're supposed to keep yourself for who you marry … I'm supposed to get married." Susy also shared that it would be nice to find a support group through church "that helps women … I could have a safe space" as she has a hard time talking to others about her PM experience and feels they would not understand.

Subtheme 1.2: Who Am I? Self-Identity in PM. In the literature, identity was discussed in relation to the loss of fertility and the inability to bear children and how those losses impacted PM Christian women (Gordon-Elliott et al., 2017; Steffen, 2011). Two participants, Nicole and Susy, both unmarried, expressed how PM has made them reevaluate their vision of the future as related to marriage, children, family and themselves. Nicole shared that she has to look for potential partners who are not interested in kids and that PM has changed how she looks at her other social relationships. Susy shared how the announcement of a friend's pregnancy was difficult on her because that was what she saw for herself, and that PM has taken "away from me

the hope of having kids."

What was not found in the literature concerning PM Christian women's identity were other ways women's identity or perceived identity changes during PM. A woman's view of herself and her identity as a person is a social construct based on interpersonal relationships with others (Sergeant & Rizq, 2017). Participants' concerns to self-identity were related to independence, life stage fit, role changes, lack of preparedness, alarm, self-esteem, emergence of something new, and changes in activity level. Ariane shared that there has been a shift in how she sees herself as a mom: "I'm no longer a young mom … transitioning … becoming a grandmother within a year … change in the stage of life … the transition of being a mom with kids at home versus being a mom of adult kids." Ariane expressed how these changes in her roles have impacted her, "maybe just having a little more freedom to invest in myself." In regard to her marriage, she also reported that she does "not have to worry about pregnancy." Other changes in her self-identity revolve around her social relationships: "I have my own circle of friends … that literally aren't because of our kids."

Eliza expressed that she was "surprised" and "not prepared" when she was informed of her PM diagnosis, and that it was "the idea of aging" that concerned her, "almost like this pride thing." Eliza reported she knew she had to have been in PM long before being officially informed by her provider, but actually hearing this information from her doctor was a shock:

> Actually, hearing the doctor say that … I was kind of not prepared for that [PM]. I was a little bit surprised and needed a few days to kind of process it and talk … I've been in PM probably long before she ever said anything but just hearing it was a bit of a shock for me … I wore this idea of I'm not gonna start menopause … till I'm like, [I'm] really old.

Eliza shared that now that she knows that she is in PM, she has taken steps to make changes in

how she takes care of her body to increase bone density and avoid osteopenia or osteoporosis.

Gabrielle shared that, in her experience, PM has affected her "in a negative way, because I can no longer do things I used to do," which includes "self-isolating" and "I'm just inside … keeping myself away from people." She expressed having a depressed mood, "I feel low on myself, like I feel I'm old." Holly also expressed that she has experienced physical (i.e., irregular menstrual cycle, decreased sex drive, increased emotionality) and emotional changes in PM that have affected her marriage and her spiritual walk. She stated there are times when she and her husband fight due to her emotions, but that "he has now come to understand that there are [emotional] changes, and he accepts that." Additionally, Holly identifies as a "spiritual woman." She stated her R/S life has been greatly affected by PM. She described how her R/S life has changed due to PM:

> I used to pray … I used to engage in my spiritual study groups, [but] sometimes I couldn't go to spiritual study groups. Sometimes I forget to pray because … [of] difficulty in concentration … Attending services has changed. At times, you wake up, maybe not feeling it, having your mood changes. So, it has really affected my spiritual life.

Holly stated, "I really try a lot to engage in my spiritual life." When feeling down, Holly will read scripture to improve her mood. She expressed that she does attempt to pray, read devotionals, and attend spiritual study groups when she is able to attend.

Sabrina shared that PM has influenced how sees herself with regard to her cognitive functioning: "there's definitely some self-doubt there, especially with the brain fog, not being able to absorb things as quickly as I used to, having to reread things. I know that I'm intelligent and capable, but sometimes I question it." Sabrina expressed how she views this transition as a

new chapter:

> In some ways I think it's just part of the next chapter in life … it's a new season that I'm experiencing, it gives me another perspective for people coming behind me … to support and encourage … my clients … I understand them right where they are, whereas when I had older clients before I hadn't reached that stage yet.

She also mentioned that with this new stage in life brings a level of confidence: "I don't really care what other people think anymore, so there is a certain confidence that comes with this [PM], like 'you don't like what I'm doing, so what?" Lastly, Sabrina shared that she and her husband are now "empty nesters" as all of their children have moved out of the home.

Subtheme 1.3: Leave Me Alone: Self-Isolation in PM. One of the many side effects of PM includes self-isolation. There are many factors that play into a PM Christian woman's self-isolation such as shame, guilt, marital tension due to diminished libido, avoidance, lack of or perceived lack of social support, and changes in social circumstances (e.g., marital separation, divorce, death of a spouse; Bromberger & Epperson, 2018; de Kruif et al., 2016; Frey et al., 2013; Gibbs et al., 2013; Grochans et al., 2018; Jagtap et al., 2016; Muslić & Jokić-Begić, 2016; Pimenta et al., 2014; Sandilyan & Dening, 2011; Sharma & Mahajan, 2015; Steffen, 2011). Several study participants (Ann, Gabrielle, Karen, Nicole) expressed significant changes in their social life, specifically their level of socialization with others, since being informed of PM. As mentioned, due to her physical and psychological PM symptoms, Ann has had to make conscious changes how she approaches her social life and whether she engages in certain activities. Additionally, she has also noticed that she has "slowed down, I don't care to go out and do as much, even when I want to go out, I just don't." She stated, "I don't spend time with my sister, or my nieces, or my daughter, or my grandkids as much as I would like to. A lot of it has to do

with I'm tired." Ann is very family oriented, but due to decreasing energy levels, she cannot always spend the time she wants with her family. Ann has found that she has to cancel or change her plans, limit the activities she engages in, or "take a deep breath and go."

Gabrielle shared that her PM symptoms have made her withdraw socially, "like keeping myself away from people." She expressed she "get[s] depressed, I don't go out … I'm just inside," and that she feels "weak, so I do no longer do things I used to do before." Gabrielle reported that despite self-isolating from friends, her role as a wife, mother, or daughter has not changed. Likewise, Karen shared that she has experienced increased depressive symptoms in PM and reported that she sometimes feels "rejected among the people around me." Nicole reported that her "social support has been okay," but that she is "the one who has been pushing them away." She stated there has been a "drastic" change in her social life and that her friends try taking her out, but "most of the time I end up ruining it by wanting to go back to my safe place." She also mentioned that she deals with people differently now than she used to before PM. Ultimately, she reported, "my friends are really complaining that I've changed a lot socially."

Primary Theme 2: I Wish I Knew More Before PM: Opening Up the Conversation

Theme 2 integrated the need for increased education and communication on the topic of PM as well as ending the stigma associated with PM to help women become more comfortable with discussing PM with their medical providers, friends, family, and other supports. The literature has discussed how women are discouraged from talking about menopause, or when the subject is broached, phrases like "she's going through the change" are used to describe the experience. Conversations about MPs were taboo; therefore, MP was not discussed, and women have been relegated to the internet to acquire information about what is happening to their bodies or to find out what is PM. A complaint Ann mentioned during her interview was how she has to

rely on the internet to get the information she needs as some of the information is difficult to determine its credibility. Women in GenX, born from 1965 to 1980 (i.e., age range 43-58 years), are about to enter PM, have been in PM for some time, or possibly postmenopausal currently. In popular culture of the 1970s and 1980s, the time GenX females were growing up, menopause was depicted in a negative manner and something to fear or not to talk about (Harper et al., 2022; see also Finestra et al., 1999; Hanalis et al., 1981; Harris & Hughes, 1986; Lear et al., 1972; Turner et al., 2002). Despite previous depictions of menopause, PM and menopause are more positively portrayed in popular culture as well as some celebrities, with the help of experts, using their platform to discuss, celebrate, complain, and normalize PM (see Cox, 2022; Fadal, 2023; Kapital Entertainment, 2022; King, 2010). For example, Drew Barrymore and Gabrielle Union discussed their experiences with PM in a segment on the *Drew Barrymore Show* (Holohan, 2023). Both actresses shared that they had experienced weight gain, mood swings, feeling "off" and misunderstood, along with other symptoms, and that it seemed to have happened overnight. They also mentioned that no one is talking about PM, instead, women are told they are crazy, bitter, or some other derogatory term (Holohan, 2023). Primary

Subtheme 2.1: PM is More Than Just Hot Flushes: Expectations. Hot flushes, a very common physical symptom of PM, is only one of many physical symptoms women experience during PM. Other symptoms of PM include insomnia, irregular menstrual cycles, night sweats, sexual dysfunction, metabolic irregularities, headaches, weight gain, random aches and pains, depressed mood, low energy, irritability, anxiety, and mental exhaustion, which negatively contribute to women's quality of life, interpersonal relationships, and occupational life (Delamater & Santoro, 2018; Elavsky, & McAuley, 2007; Frey et al., 2013; Gibbs et al., 2013; Hunt, 2016; Levin, 2015; Mauas et al., 2014; Pagán, 2018; Sandilyan & Dening, 2011; Terauchi

et al., 2013; Woods & Mitchell, 2011; Worsley et al., 2014). As stated earlier in this chapter, the participants in this study reported a wide range of physical, biological, mental, emotional, and psychological symptoms related to their overall PM experience such as headaches (eight); hot flushes (eight); insomnia (six); irregular menstrual cycles (seven); metabolic irregularities (seven); night sweats (10); random aches and pains (seven); sexual dysfunction (six); weight gain (seven); anxiety (eight), cognitive deficits such as "brain fog," confusion, and forgetfulness (nine); depression (five); emotional instability (six); hostility (two); and irregular mood (six).

All participants in the study expressed that they wished they knew more about PM before their experience with PM. Ann stated, "I wish I knew what PM was before I knew what PM was." She expressed frustrations over not knowing what to expect during this time and that "these things weren't really talked about" when growing up. She discussed not having a clear idea of PM because most of the women she turned to for advice had had a hysterectomy and did not have much feedback to provide. Ariane shared a similar dilemma associated to PM: "my mom had had a hysterectomy and so she had no idea … it is in her 30s," and added, "So I had no way to gauge when I am going to hit it." She also mentioned her menstruation experience, as compared to her younger sister, was very different, "getting her period way before I ever did, and I'm older than her … I'm getting super heavy periods every 3 weeks, and she's not getting anything! How's that work? So even gauging on siblings, I couldn't … It feels so mysterious."

Nicole expressed, "I wish I could have a lot of enlightenment about it [PM] before now … the symptoms, be aware of the symptoms and not having to go to the physician for them." Regina made a similar comment: "I would have liked to know more about detailed symptoms." Susy shared that in her experience and due to her age at the outset of PM, "there's not much information out there," and added:

> there's some pain involved, I don't mean physical, I mean more just emotional … the ideas that you had prior to PM, and how you're having to make those changes … looking at the future, what the future may hold for you. Just having to deal with those disappointments or possible disappointments.

Subtheme 2.2: We Need to Talk: Communication, Education, and Awareness of PM. All participants of this study expressed the need for more communication, education, and awareness of PM. As mentioned, many study participants were unaware of what has happened to their bodies was PM. Words and phrases identified through the analysis such as, "mysterious,, "challenging," "blindsided," and "I'm guessing" (Ariane), "mystery" (Eliza), "negative" (Karen and Nicole), and "scary" (Susy) were used to describe participants' first thoughts about PM. Fear of the unknown is typically due to the perceived lack of information concerning, in this study for example, an individual's health condition (Carleton, 2016). All study participants acknowledged they did not have a lot of knowledge about PM prior to being informed about PM, hence the use of the words mentioned at their first thought of PM. Many of the symptoms of PM can be frightful at initial onset.

All participants expressed the need to increased awareness, education, and communication on PM and menopause, particularly on what to expect during PM; however, several participants (Ann, Ariane, Eliza, Gabrielle, Regina, Sabrina) made specific suggestions on ways to disseminate information and create awareness to this natural biological phenomenon. Ann stated, "it needs to be a conversation that men and women need to have, it needs to be an open line of communication and that men need to know that their women are hurting and sometimes suffering in silence because they are afraid to tell their husbands." Ariane suggested there should be increased education particularly on symptoms one would not immediately

associate with PM (e.g., “weird body aches”). Eliza recommended increased education on the “biological mechanics … maybe understood more [of] the biology of what actually goes on in menopause. I guess that really would come from OB/GYNs, maybe therapists as well,” and continued with, “when [at] a checkup from the doctor, which women are gonna do well before PM, maybe there could be just a brief mentioning [of PM], just so that you know [what’s] coming up … maybe bringing it up a little bit before they [women] reach that [PM].” Gabrielle suggested, “meetings should be held to enlighten women who are interested … to learn more about PM and menopause, and what to expect.” Regina provided, “educating them on the symptoms [of PM], maybe online classes to educate people more on what to expect during PM.” Sabrina proposed helping women understand:

> That there are ways to take care of it [PM] and that you don’t just have to suffer. Printing information is key to knowing that those are potential symptoms, but they’re not a death sentence. We’ve learned so much in the last 20 years about PM and menopause that we can’t look at it the way we did, the way our mothers did. It’s a different time. It’s so you can pursue a healthy approach to it. It doesn’t have to take over your life. I think I can sum all of it up with knowledge is power.

Subtheme 2.3: Destigmatizing PM: It Is No Longer a Taboo Subject. Despite advances in modern medicine and technological advances that have increased access to information, it was not that long ago that discussion of PM or menopause was considered taboo and not discussed. As mentioned, GenX women (43-58 years) are about to begin PM, are in PM, or are now in postmenopause. For these women, several of whom are participants in this study (Ann, Ariane, Eliza, Sabrina), there were not too many positive depictions of menopause in popular culture (e.g., negative symptomatology on top of perceived emotionality, aggressiveness,

and inability to perform from others, made to feel old or useless), nor was PM or menopause discussed by their mothers, grandmothers, or elder female friends while growing up (Harper et al., 2022; Sergeant & Rizq, 2017; see also Finestra et al., 1999; Hanalis et al., 1981; Harris & Hughes, 1986; Lear et al., 1972; Turner et al., 2002). Ann shared that in her experience: "when we were kids, it really wasn't talked about, about periods. My mom didn't talk to me about how to put a tampon in, sex education really wasn't a thing. I mean it was, but it wasn't." Furthermore, Ann expressed being afraid to talk to her husband about what she was experiencing and that:

> Women [should] not be afraid to talk, [PM] not being so taboo to talk about … it needs to be a conversation that men and women need to have … an open line of communication. Men need to know that their women are hurting and sometimes suffering in silence because they are afraid to tell their husbands … I should not have been afraid to tell him. It's always been taboo. It [PM] needs to be okay to talk about it.

Ariane expressed her mother had a hysterectomy in her 30s: "she had no idea she had [PM]. She had no hormones … making it [PM] more of a conversation. People just don't talk about it, and so we're all kind of blindsided because it feels like the topic is skirted, but not really addressed."

A "perceived social etiquette" of not speaking about menopause further perpetuates this negative discourse and perception from others (Sergeant & Rizq, 2017; p. 197). Nevertheless, PM and menopausal women are reluctant to share their stories out of fear of false perceptions about their skills and abilities. They do not want to be seen as old, incapable, useless, washed up, or frumpy. For Eliza, it was "the idea of aging" that disturbed her, "almost like this pride thing." She admitted that the knowledge of being in PM has been "challenging, and it's humbling, and it keeps me in check, I guess." However, due to the negative perceptions surrounding PM and

menopause, the likelihood of positive, dynamic, attractive, and successful PM or menopausal roles models diminishes, particularly in countries where older women are not held in high regard and respected for their age, wisdom, and place in the family (Sergeant & Rizq, 2017). Conversely, there has been an emergence of more positive narratives about PM and menopause from celebrities using their platform to break down the barriers, destigmatize, inform, and bring awareness of PM and menopause (see Cox, 2022; Fadal, 2023; Holohan, 2023; Kapital Entertainment, 2022; King, 2010). Sabrina commented on her experience with all of the negativity concerning PM and menopause:

> I think that there's so much out there in the news and articles and social media and all that, that PM and menopause are a terrible thing, that it's going to be miserable and awful and insufferable, and just going to be a nightmare. During that time, I wish I had seen the positive side of it … Finding the confidence, finding the balance, realizing that I can take charge of me and do for me the things I need to. Knowing that it would move into this next stage with the realization that I'm still every bit as much of a woman as I was before, maybe even more of one because now I'm able to stand up and say this is who I am. I've got this. I'm still capable with PM … It's not the end of life to go in PM. I wish there was more of that.

Primary Theme 3: There is a Light at the End of the Tunnel: Positive Coping

There are numerous coping strategies that can be used to cope with the physical, biological, psychological, emotional, mental, and cognitive symptoms of PM. Participants shared the coping strategies that have implemented and the efficacy of these strategies in managing their symptoms of PM. Coping strategies are applied to lower stress, symptoms of anxiety and depression, or other difficulties that adversely affect well-being (Millacci, 2017). Coping

strategies span the continuum from positive (healthy) coping skills (e.g., management of emotions, social support, increased communication, hobbies, prioritization of self, delegation of authority, self-care) to negative (unhealthy) coping skills (e.g., abusive behaviors, addiction, avoidance of problems, self-harm, isolation), and are unique to each person. Protective factors, also unique to the individual, allow for positive adjustment when confronted with difficult situations or circumstances (Wilson, 2021). Protective factors assist in regulation of emotions, make meaning, and promote relational growth. Examples of protective factors include emotional awareness, emotional regulation, honesty, humility, anger management, one's purpose in life, R/S, family involvement and attachment, compassion, supportive social relationships, ability to forgive, physical development, self-esteem, community engagement, and boundaries and expectations for self and others.

All participants coped with PM in different ways such as "natural remedies," "relying on God and His guidance" (Ann); "exercise" (Ann, Ariane, Eliza, Gabrielle, Holly, Karen, Regina); "sleep" (Ariane, Gabrielle); "being intentional to do the things that lead to more peace and calm", "increasing self-care", "hot tub" (Ariane); "spirituality", "live for God" (Eliza); "eat healthy and drink water," "engage a lot with things that will keep me spiritually active, emotionally active" (Holly); "church activities," "hang out with friends" (Karen), seek out mentoring "the choir lady in my church … told me how my lifestyle could change … and how I can take care of myself" (Nicole); "nutrition," "good communication with my husband," "step away from the busyness," "go to the gym," "eat healthy" (Sabrina), and "therapy" (Susy).

Summary

In this chapter, the findings of the lived experiences of PM Christian women were discussed. Specific details with regard to the setting for the personal virtual interviews with

participants and participant selection were considered. Participants of this study were described individually to share their specific stories and experiences with PM, and as a group. Three primary themes emerged from participant responses. The first primary theme centered on the participants' biological, physical, psychological, emotional, mental, cognitive, social, relational, and R/S experiences to PM (Subtheme 1.1: The Change is For Real: Bio-Psycho-Social-Spiritual Changes in PM), issues with identity (Subtheme 1.2: Who Am I?: Self-Identity in PM), and self-imposed isolation (Subtheme 1.3: Leave Me Alone: Self-Isolation in PM). There was a lot of ambiguity and apprehension expressed in participants' emotions, which is the result of many factors such as contradictory information provided (i.e., stages of MP, length of time, ages, expectations, symptoms involved), uninformed about PM (due to a lack of or access to resources), shame or embarrassment, guilt, stigma, or had previous bad experience with a medical professional (e.g., misdiagnosed, feeling ignored or brushed off, misinformed), among other reasons. Hence, they do not understand what is happening with their bodies, are stressed, scared, or uncertain. Furthermore, due to these changes, many participants expressed the need to self-isolate or limit their social interactions.

The second primary theme focused on the lack of awareness of expectations and the need to know what to expect in PM (Subtheme 2.1: PM is More Than Just Hot Flushes: Expectations), for increased education and communication on the topic of PM and suggested recommendations (Subtheme 2.2: We Need to Talk: Communication, Education, and Awareness of PM), and ending the stigma associated the PM and menopause to empower women to discuss their PM experience with their personal and professional support systems (Subtheme 2.3: Destigmatizing PM: It Is No Longer a Taboo Subject). Several study participants are part of GenX, were witness to negative stereotypes and limited information on PM and menopause, and expressed the need

for more information, more formalized information, and increased conversations with, not only women, but men on PM. Younger participants also expressed a need for increased information as they were "surprised" by going into PM at their age. All participants coped with PM in different ways, and in the third theme, participants shared their various coping strategies to combat symptoms of PM. Reliance on God, faith, and spirituality were prominent among participants (Ann, Eliza, Holly, Karen, Nicole). Other coping strategies used to manage PM symptoms include "natural remedies" (Ann), "exercise" (Ann, Ariane, Eliza, Gabrielle, Holly, Karen, Regina, Sabrina); "sleep" (Ariane, Gabrielle); "do the things that lead to more peace and calm," "increasing self-care," "hot tub" (Ariane); "hang out with friends" (Karen); "nutrition" (Holly, Sabrina), "good communication with my husband," "step away from the busyness" (Sabrina).

All 10 participants shared similar experiences with regard to PM (i.e., physical and psychological symptoms of PM). Unique characteristics to each participant were also explored (e.g., age of onset of PM, severity of physical symptoms, mental health issues experienced, coping strategies). All participants shared how their lack of knowledge on PM contributed to their overall PM experience and expressed the need for increased communication, education, and conversation on PM. Many expressed they did not know what to expect, were "blindsided" (Ariane) or "surprised" (Eliza), and "afraid" (Ann) to talk about their experiences with significant others. Despite the negative information that is produced about PM, Sabrina shared that she wished she had seen the positive side of PM that she sees now, "finding confidence, balance…I can take charge of me… I am every bit as much of a woman as I was before … stand up and say this is who I am… I'm still capable with PM… It's not the end of life."

Chapter 5 explains how the findings of the study connect to the RQs posed for the study and how the findings connect and expand on the current literature. The chapter also validates the

theoretical framework. Further, it discusses implications, demarcations and limitations of the study, recommendations for support systems, and areas for future study.

CHAPTER FIVE: CONCLUSION

Overview

The purpose of this phenomenological study was to survey the lived experiences of PM Christian women from a bio-psycho-social-spiritual perspective through the lens of feminist theory. This chapter comprises a summary of the study findings associated to the RQs posed in the study. A discussion of how the findings relate to and expand on the current literature and the theoretical framework of this study is also presented. Implications, demarcations and limitations of the study, and recommendations for support systems are discussed in detail. Finally, areas or future study wrap up the chapter.

Summary of Findings

Three primary themes emerged from this phenomenological inquiry into the lived experiences of PM Christian women: I Don't Understand What is Happening to Me, Why Do I Feel this Way All of a Sudden?, I Wish I Knew More Before PM: Opening Up the Conversation, and There is a Light at the End of the Tunnel: Positive Coping. The Central RQ and the four additional RQs presented in this study were addressed through the themes that emerged from the participant responses. Areas for future study were also discovered throughout the course of this study and will be addressed later in this chapter.

RQs Addressed

The Central RQ driving this study was "How would PM Christian women describe their physical, psychological, mental, emotional, relational, and R/S lived experiences?" The participants' responses indicated they shared similar physical and psychological symptoms: headaches (eight); hot flushes (eight); insomnia (six) irregular menstrual cycles (seven) metabolic irregularities (seven) night sweats (10); random aches and pains (seven); sexual

dysfunction (six); and weight gain (seven); anxiety (eight), cognitive deficits such as "brain fog," confusion, and forgetfulness (nine); depression (five); emotional instability (six); hostility (two); and irregular mood (six). In addition to the physical and psychological symptoms the participants experienced, they also discussed how their social and R/S lives were affected due to their PM symptoms. Several participants (Ann, Gabrielle, Karen, Nicole) shared how their social lives have dramatically changed because of self-isolation or made "drastic" (Nicole) changes that limited their level of socialization with friends, family, or other outside sources of support (e.g., church services). Several participants (Ann, Holly, Nicole, Susy) also expressed how their R/S lives have changed for the better or worse because of their PM symptoms. Despite not being able to attend services as she once had, Ann also shared that her faith has grown even stronger through her experience, whereas Susy stated that her PM experience has her "questioning a lot of things" related to her R/S life because she is having to reevaluate her future. The following sections will discuss how each of the RQs were addressed by the themes that emerged from the data collected from the participants.

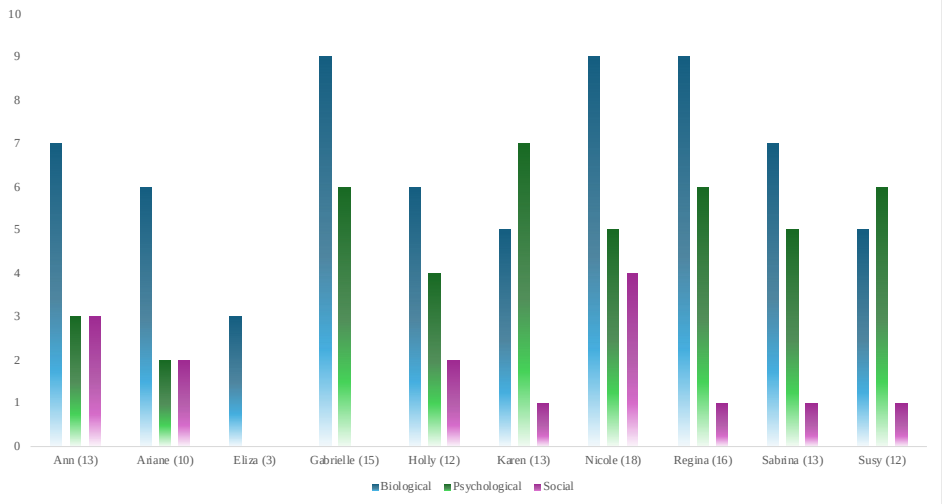
RQ 1: How Do Participants Describe Their Physical Health During PM?

RQ 1 was attended to predominantly in Primary Theme 1. The focus of Primary Theme 1 were the bio-psycho-social-spiritual changes in PM (Subtheme 1.1), self-identity in PM (Subtheme 1.2), and self-isolation during PM (Subtheme 1.3). Much has been documented on the physical symptoms of PM (e.g., insomnia, irregular menstrual cycles, night sweats, hot flushes, sexual dysfunction, metabolic irregularities, headaches, weight gain, random aches and pains; Delamater & Santoro, 2018; Elavsky, & McAuley, 2007; Frey et al., 2013; Gibbs et al., 2013; Hunt, 2016; Levin, 2015; Mauas et al., 2014; Pagán, 2018; Sandilyan & Dening, 2011; Terauchi et al., 2013; Woods & Mitchell, 2011; Worsley et al., 2014). The participants of this study

reported similar physical symptomatology with the top three biological or physical symptoms reported being night sweats, headaches and hot flushes; and irregular menstrual cycles, metabolic irregularities, random aches and pains, and weight gain (see Figure 6), consequently affecting quality of life. Quality of life, theoretically, is an equilibrium of bio-psycho-social-spiritual functioning (Jafary et al., 2011). If stability is not met, especially for an extended period of time, quality of life will suffer (Frey et al., 2013; Sandilyan & Dening, 2011; Sharma & Mahajan, 2015). For example, Gabrielle expressed that her PM symptoms had affected her "in a negative way, because I can no longer do things I used to do." Ann similarly stated that she has had to cancel plans, change her plans, limit her activities, or push herself to stay committed to her plans due to physical PM symptoms. Holly further mentioned that her physical PM symptoms affect whether she attends church services or spiritual study groups, which has "really affected" her R/S life.

Figure 6

Total Number of Symptoms Reported by Each Participant



Subtheme 1.2 and Subtheme 1.3 partially addressed RQ 1, specifically about how physical PM symptoms influenced participants' self-identity and desire to self-isolate. Subtheme

1.2 noted how participants perceived themselves in PM. Several participants (Ariane, Eliza, Gabrielle, Holly, Nicole, Susy) mentioned how their self-identity has shifted because of PM, either because of their perceived inability to have children (Nicole and Susy), or the transition to the next life stage (Ariane, Eliza, Gabrielle, Holly). Previous research has also discussed how self-identity related to loss of fertility and inability to bear children and how those losses can influence PM Christian women's self-identity (Gordon-Elliott et al., 2017; Steffen, 2011). Due to the start of PM at a younger age, two participants, Nicole and Susy, both unmarried, shared how PM has forced them to reexamine how they see their future related to marriage, children, family, and themselves. When looking for a partner, Nicole expressed that she has to find someone who is not interested in kids. She also stated that she has had to reevaluate her other social relationships with friends. Susy indicated that PM has taken "away from me the hope of having kids" and how difficult it was when she recently discovered a friend's pregnancy as that was something she saw her future.

Several participants (Ariane, Eliza, Gabrielle, Holly) in this study also noted changes in their self-identity related to the transition to a new life stage or something new, independence, role changes, lack of preparedness, alarm, self-esteem, and changes in energy or activity level. A woman's perception of her self-identity is socially constructed and centered on interpersonal relationships with others (Sergeant & Rizq, 2017). Ariane's perception of herself as a mom, wife, her own person, and a friend has taken a shift since PM: "I'm no longer a young mom … transitioning … becoming a grandmother within a year … change in the stage of life." Eliza shared that it was "the idea of aging" that bothered her: "I wore this idea of I'm not gonna start menopause … till I'm like, [I'm] really old." Gabrielle shared that she does not spend much time around people since being informed of PM, and stated, "I feel I'm old." Holly reported that the

physical and psychological changes she has experienced since PM have affected her marriage and spiritual walk. She stated there have been times when she and her husband fight due to her emotions getting the better of her, but she expressed her husband "has now come to understand that there are [emotional] changes, and he accepts that."

Subtheme 1.3 centered on participants' desire to self-isolate or limit social interactions. Shame, guilt, and lack of or perceived lack of social support, among other reasons, play a role in self-isolation (Bromberger & Epperson, 2018; de Kruif et al., 2016; Frey et al., 2013; Gibbs et al., 2013; Grochans et al., 2018; Jagtap et al., 2016; Muslić & Jokić-Begić, 2016; Pimenta et al., 2014; Sandilyan & Dening, 2011; Sharma & Mahajan, 2015; Steffen, 2011). In this study, three participants (Ann, Gabrielle, Nicole) shared they made substantial changes in their social lives due the physical symptoms they experienced during PM. Ann shared that due to decreasing energy levels, she has "slowed down, I don't care to go out and do as much. … A lot of it has to do with I'm tired." Gabrielle expressed that she feels "weak, so I no longer do things I used to do before," which includes not spending time with friends. Nicole's physical PM symptoms significantly affect her social like and she stated she is "the one who has been pushing them [friends] away."

Primary Theme 2 partially addressed RQ 1 in that the focus of Primary Theme 2 was on the desire to know more about PM before the experience of PM, specifically on what to expect during PM (Subtheme 2.1) and the need for increased communication, education and awareness of PM for women and their support systems (Subtheme 2.2). Several study participants (Ann, Ariane, Nicole, Regina, Susy) vented that they would have liked to have known more about PM before their experience with PM. They shared their frustrations with not knowing what to expect during PM and their need for more information and communication on the subject of PM. Ann

indicated that, “I wish I knew what PM was before I knew what PM was.” Nicole expressed she would have liked to have known more about the symptoms before going to her physician. Regina shared a similar comment: “I would have liked to know more about detailed symptoms.” Lastly, Susy expressed that “there’s not much information out there” about PM, especially for women of her age.

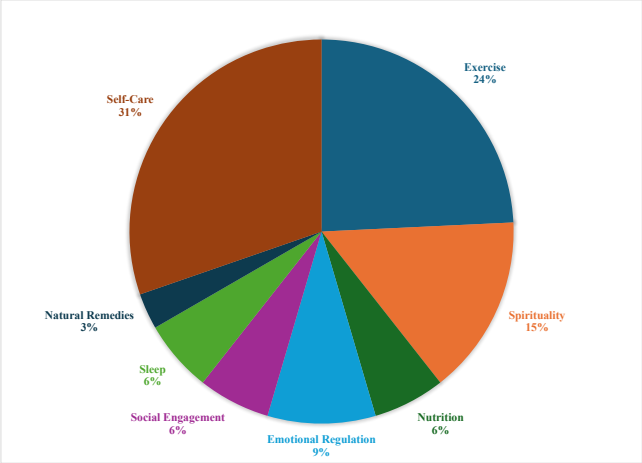
Subtheme 2.2 centered on the need to open up the conversation about PM, increase communication, provide education and resources, and bring awareness of PM to the general public as this is a societal issue, not just a women’s health issue. All the participants had suggestions on how to increase awareness, improve communication, and offer resources to assist women who are in premenopause to prepare for what they will experience in PM. Ann suggested that PM “should not be taboo to talk about” and suggested the conversation should include men and how they can support the PM women in their lives. Ann shared how she feared talking with her husband about her physical PM symptoms for a long time before sharing her experience, despite her husband being “a big key part” of her support system. Eliza stated she felt it was important to know the “actual biological mechanics [of PM]” as it was a “bit of a mystery” for her. She suggested doctors should introduce the subject of PM to their female patients during their annual physical exam well before PM begins to help them understand and know what to expect in PM. Gabrielle suggested meetings should be held for women to discuss their PM experiences and receive proper information about PM symptomatology. Holly and Susy, two of the younger participants of this study, shared that awareness is needed, especially because their PM experience began earlier than for most women. Nicole expressed a similar idea as Eliza in that women ought to be “educated about PM even before they get to that stage.” Regina mentioned similar ideas about the need for education and awareness of PM, “maybe online

classes to educate people on what to expect." Lastly, Sabrina suggested the use of print media to disseminate information on PM specific to potential symptoms and expectations, and "that it's [PM] not a death sentence."

Finally, Primary Theme 3 moderately contributed to RQ 1 in that participants discussed ways they are positively coping with their physical PM symptoms. Numerous coping strategies and protective factors are available to women to cope with the physical symptoms associated with PM. Despite the various differences in coping strategies, all of the participants in this study shared the coping strategies they used for the management of their PM symptoms. All participants engaged in some form of self-care (e.g., "hanging out with friends" [Karen], sleeping, spending time in the "hot tub" [Ariane], "stepping away from the busyness" [Sabrina]). Most of the participants (Ann, Ariane, Eliza, Gabrielle, Holly, Karen, Regina, Sabrina) shared that exercise had been beneficial in handling their symptoms. Five participants (Ann, Eliza, Holly, Karen, Nicole) expressed that spirituality was important for the management of their symptoms. Emotional regulation (e.g., therapy, engagement in activities that bring peace and calm); "eat healthy," "drink water," and "nutrition;" social engagement; sleep; and natural remedies were all shown to be effective in helping participants manage their physical PM symptoms. The following pie chart illustrates the percentage of the coping skills utilized by participants in this study.

Figure 7

Percentage of Coping Skills Utilized by Participants



RQ 2: How Do Participants Describe Their Mental Health During PM?

RQ 2 was also addressed by Primary Theme 1, which focused on the bio-psycho-social-spiritual changes, shift in self-identity, and self-isolation related to PM. Commonly presented in the research, erratic hormone levels, despite a biological symptom of PM, can present as mental health concerns. PM women have a higher chance for reoccurrence of, or initial onset of, major depressive disorder or anxiety, as well as to experience other mental, emotional, and cognitive issues during PM than other phases of menopause, with depression being the primary complaint (Becker et al., 2007; Blackmore et al., 2008; Bromberger & Epperson, 2018; Bromberger et al., 2007, 2011; Delamater & Santoro, 2018; Elavsky & McAuley, 2007; Flores-Ramos et al., 2018; Gibbs et al., 2013; Hunt, 2016; Jagtap et al., 2016; Karkhanis & Mathur, 2016; Levin, 2015; Mauas et al., 2014; Pagán, 2018; Pearson, 2010; Sandilyan & Dening, 2011; Terauchi et al., 2013; Woods & Mitchell, 2011; Worsley et al., 2014).

The findings of this study were somewhat different than what has been presented in current literature in that symptoms of anxiety appeared more frequent with this study's participants. Ann reported she has experienced "anxiety even as a little girl," and Ann has found

herself “more emotional [now] than I have ever been in my life.” Ann shared that it does not take much for her to cry for little to no reason. Gabrielle shared that, in her experience, anxiety, cognitive deficits, confusion, depression, forgetfulness, and irregular mood significantly contributed to her negative PM experience, “because I can no longer do things I used to do.” She expressed she is depressed by her physical PM symptoms and self-isolates. Holly reported she has experienced cognitive deficits, emotional instability, hostility, and irregular mood that have carried over into her marital relationship resulting in fights. She also shared that due to difficulties with concentration, “sometimes I forget to pray,” and then due to mood changes, she may not attend services. This has affected her self-identity in that she sees herself as a “spiritual woman.” Karen expressed she has faced anxiety, cognitive deficits, confusion, depression, emotional instability, forgetfulness, and hostility. She also reported that she feels rejected by the “people around me and in relationship with people.” Nicole shared that she has experienced anxiety, cognitive deficits, depression, emotional instability, forgetfulness, and irregular mood. She reported getting “irritated very quickly, emotions could shift from being happy to being rude and sad in a few minutes.” Nicole expressed that is not going out with her friends like she used to. Regina reported that she has experienced “depression for about a period of like, roughly 2 to 3 years.” Sabrina’s psychological, mental, and emotional symptoms consisted of anxiety, cognitive deficits, emotional instability, forgetfulness, and irregular mood, which impacted how she perceived herself with respect to her cognitive functioning. Susy shared that PM has been “scary” for her and has brought on “a lot of anxiety.” She expressed she has a hard time talking to anyone about her PM experience and feels no one will understand what she is going through because of her age.

Ariane shared a different experience about her psychological, mental, and emotional

health. She reported she has noticed an improvement since her PM symptoms began, “would say it’s [mental health] improved … the instability and irritability is just, it’s just not there anymore.” Additionally, Ariane expressed with the changes in her roles, comes a shift in self-identity. With these role changes she has found that she has more time to “invest in myself.” Eliza also specified she had a different kind of experience in that she did not exhibit any psychological, emotional, and mental health symptoms during PM. Eliza reported she went through a brief period of time after being told she was in PM by her OB/GYN that she was “surprised” and “not prepared for that,” and stated, “I was a little bit surprised and needed a few days to kind of process it and talk with friends and just kind of work my mind around it.”

Subtheme 2.1 and Subtheme 2.2 of Primary Theme 2 concentrated on expectations and the increased need for communication, education, and awareness of PM. There are numerous physical symptoms women may experience during PM, such as insomnia, irregular menstrual cycles, night sweats, sexual dysfunction, and mental exhaustion, which can negatively contribute to women’s quality of life, interpersonal relationships, and occupational life (Delamater & Santoro, 2018; Elavsky, & McAuley, 2007; Frey et al., 2013; Gibbs et al., 2013; Hunt, 2016; Levin, 2015; Mauas et al., 2014; Pagán, 2018; Sandilyan & Dening, 2011; Terauchi et al., 2013; Woods & Mitchell, 2011; Worsley et al., 2014). The participants of this study were no different in their report of symptoms experienced during PM or how those symptoms impacted their quality of life. However, all of the participants in this study expressed they lacked the knowledge of what to expect during PM and articulated the need for increased communication, education, and awareness of PM. The words “uniquely awful” and “disempowering” have been used to describe the emotions women feel when they do not understand what is going on with their bodies or why (Gunter, 2021). Fear of the unknown and uncertainty is quite high for women in

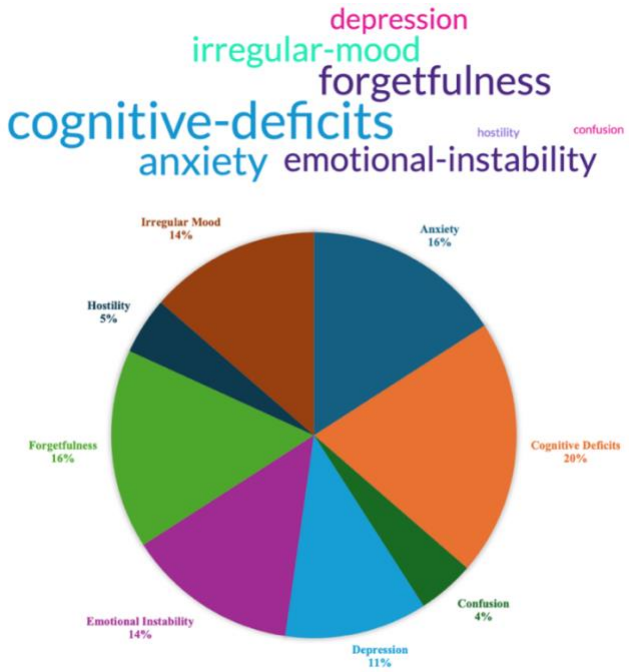
PM is due to lack of knowledge of their health condition (Carleton, 2016). Furthermore, there is a need for increased communication and education of PM to create awareness, not just for those who are or will experience PM and menopause, but for those who support women will experience PM and menopause.

Primary Theme 3 examined coping strategies and protective factors participants used when managing their psychological, emotional, or mental health issues related to PM. Participants of this study had varying coping strategies and protective factors. Ann reported her faith helps her cope: "my faith is strong … I'm relying on God and His guidance." Ann also shared that she has elected to take a natural approach to treat and cope with her PM symptoms with the assistance of a naturopath doctor. Similarly, Holly indicated she will read scripture when she is feeling down, and this helps lift her mood. She revealed that she has been really affected by PM, "but I really try a lot to engage in my spiritual life." Nicole expressed that she has increased her time with God to cope with the physical, mental, and social side effects of PM. She reported she is taking her time "just to read and understand the Bible" and move closer to God, to which she reported improvement in her spiritual health. Ariane shared that, "being intentional to do the things that lead to more peace and calm" have helped to improve her mood. She and her husband "have a good network of friends at church" that have been a support for her, as well as new friends she has made in her graduate program. Eliza reported that since being told she is in PM, she now takes care of her body. Regina also reported that exercise has been helpful to reduce her symptoms of PM. Sabrina explained that she approaches by paying attention to what her body is telling her and is more purposeful when it comes to how she takes care of herself, "realizing that I need to save space for myself, that I need to take breaks, that it's okay to sit and have a piece of dark chocolate when feeling a little down but I don't need to eat

the whole bag." She also reported prioritizing herself instead of "always being on the go for everyone else." Gabrielle expressed that she is no longer engaging in activities she used to do before being informed of PM and she stays inside, all signs of negative coping strategies. In contrast, Susy reported that due to her age at the onset of PM and being unprepared for PM, she has been coping by seeing a therapist. Figure 8 depicts the percentage of reported psychological, emotional, mental, and cognitive symptoms of PM by study participants and a representative word cloud.

Figure 8

Percentage of Psychological, Emotional, Mental, and Cognitive Symptoms and Word Cloud



RQ 3: What were the Social/Sexual Experiences of PM Christian Women?

Like the other questions, RQ 3 was mainly answered by Primary Theme 1. Despite hormonal fluctuations that can contribute to physical and emotional difficulties during PM, social issues can develop or intensify such as dysfunctional familial, friend, or intimate partner relationships; financial issues; lack of or perceived lack of social support; or other adverse life

events that possibly lead to withdrawal, avoidance, or self-isolation (Bromberger & Epperson, 2018; de Kruif et al., 2016; Frey et al., 2013; Gibbs et al., 2013; Grochans et al., 2018; Jagtap et al., 2016; Muslić & Jokić-Begić, 2016; Pimenta et al., 2014; Sandilyan & Dening, 2011; Sharma & Mahajan, 2015; Steffen, 2011). The participants of this study reported many of these social factors as part of their PM experience. Ann shared that during PM she experienced adverse life events (i.e., loss of parents), employment issues, and relationship difficulties. Additionally, as a result of decreased energy levels, Ann has had to make changes to how she approaches her social life. Despite the changes to her social life, Ann does have supportive friends and relatives that she relies on for support. Ariane reported she has many roles she plays in her life that have now evolved, particularly her role as a mother and now soon-to-be grandmother, thus allowing her to have more time and "freedom to invest in myself." She expressed that she now has her "own circle of friends that are not friends … because of our kids." Ariane shared that she and her husband "have a good network of friends at church" and through her program at school who have been a "definite source of support." Holly shared that decreased libido, increased emotionality, and changes in her menstrual cycle have carried over into her marital relationship, but they are able to "come to terms later and understand that there are changes in life in a woman, there are changes emotionally."

Despite these positive experiences with support, Karen reported her PM experience has her feeling "a lot more negative" due to increased emotionality, overthinking, and memory lapses. Additionally, she expressed feeling "rejected among the people around me" since being in PM. Nicole also expressed PM has had a "mostly negative[ly]" impact on her life and has influenced who she is looking for in a life partner, "I started looking out for men who were not interested in kids." Furthermore, she has found herself pushing people away, and admits that her

"social support has been okay," but "I just don't deal with people like the way I used to deal with people… I have been a bad friend since PM… My friends are really complaining that I've changed a lot socially." Sabrina shared one of the biggest shifts for her since PM has been to become a business owner, "instead of working for somebody else, that's probably the biggest change." She expressed she has learned that she needs to make herself the priority instead of "always being on the go for everyone else." Susy reported, she too, has to reevaluate who she chooses as a life partner as she is unmarried and does not have children. Susy stated, "it [PM] takes away from me the hope of having kids." Susy also mentioned that she finds it difficult to talk to other women about PM as she feels they would not understand because of her age. Finally, Gabrielle reported that, even though she may isolate from friends, she does not feel her roles as a wife, mother, or daughter has changed.

Subtheme 2.3 from Primary Theme 2 concentrated on destigmatizing PM and breaking down the barriers that are preventing PM Christian women from talking openly about their experiences with PM. Discussion of PM and menopause was considered taboo and either not discussed or spoken about in hushed tones, and definitely not discussed in mixed company. GenX women (43-58 years old) who are about to enter PM, have entered PM, or are about to transition to postmenopause, were not exposed to positive PM or menopause experiences growing up. In popular culture negative symptomatology; increased emotionality; dismissive reactions from others; accusation of aggressiveness; and women made to feel old, useless, incapable, guilty, or shameful, were prevalent messages for female GenXers in the late 1970s to early 1990s (Harper et al., 2022; Sergeant & Rizq, 2017; see also Finestra et al., 1999; Hanalis et al., 1981; Harris & Hughes, 1986; Lear et al., 1972; Turner et al., 2002). Furthermore, PM or menopause was not discussed in the home by mothers, grandmothers, or elder female friends,

which promotes negative discourse and perception from others (Sergeant & Rizq, 2017). Four of this study's participants (Ann. Ariane, Eliza, Sabrina) are female GenXers and share similar experiences of PM or menopause not being discussed while growing up. Additionally, Ann shared that she was afraid to talk to her husband about her PM experience. Ariane expressed PM needs to be "more of a conversation. People just don't talk about it, and so we're all kind of blindsided because it feels like the topic is skirted, but not really addressed." Notwithstanding all of the negativity surrounding PM and menopause, Sabrina shared that she has been able to find confidence: "I'm still capable with PM … It's not the end of life to go in PM."

RQ 4: What Did PM Christian Women Experience in Their R/S Life?

RQ 4 was specifically addressed by Primary Theme 1, in Subtheme 1.1 and Subtheme 1.2, and Primary Theme 3. As discussed in prior sections, the hormonal fluctuations during PM lead up to the nonreproductive point of a woman's life and brings about physical and psychological changes that can impact the social and R/S aspects of a women's lives (Bromberger et al., 2001; Delamater & Santoro, 2018; Elavsky & McAuley, 2007; Frey et al., 2013; Gordon-Elliot et al., 2017; Hunt, 2016; Mauas et al., 2014; Jafari et al., 2014; Muharam et al., 2018; Onder & Batigun, 2016; Sandilyan & Dening, 2011; Sharma & Mahajan, 2015; Shokri-Ghadikolaei et al., 2022; Treloar, 1981). For women who closely identify as family-oriented, to no longer have the ability to have and raise children any longer due to PM can be especially difficult (Steffen, 2011). On the other hand, R/S can have a positive influence in decreasing menopausal symptoms as their R/S allows PM women to feel at peace, adds meaning to life, brings compassion, and forgiveness of self and others (Steffen, 2011).

Several participants (Ann, Ariane, Holly, Nicole, Regina, Susy) indicated changes that have occurred in their R/S lives related to PM. Some of the complaints are associated with how

decreased energy levels impacted their level of participation (Ann, Holly, Regina) and questioning God (Nicole, Susy), while another complaint was related to poor concentration (Holly). Ann shared that due to the physical symptoms of PM, her participation in R/S activities has decreased; however, she still has strong faith. Ariane shared that she and her husband decided to "not try for pregnancy anymore" due to the traumatic loss of two pregnancies. She questioned whether she made the best decision to stop trying for more children, but she is "Working towards opening my hands to whatever God has for me." Holly reported that her R/S participation has been "really affected" by her PM symptoms, but she does engage in her R/S life when it is possible. Nicole shared, in spite of obstacles she has endured due to PM (i.e., reevaluate future plans for marriage and children, physical and psychological PM symptoms), she reported she has been more intentional about spending more time reading and understanding the Bible and wants to "move in closer to God." She expressed this has positively affected her spiritual growth and has given her "the opportunity to be an usher in my own church." Regina expressed a similar issue in that, due to her PM symptoms, she is often too tired to pray, which greatly bothered her. Susy, who is the youngest study participant and unmarried, expressed that she would like to find a faith-based support group as she shared she has difficulty talking to others about PM and feels they would not understand because of her age.

Discussion

In this section, connections are made to the current literature and theoretical framework related to the bio-psycho-social-spiritual aspects of PM from a feminist theoretical perspective and how this study expands on the current literature and extends the theoretical framework. Additionally, coping mechanisms and protective factors associated with managing the symptoms of PM are explored. Connection to the current research and expansion on the current literature

are essential to furthering the knowledge base and filling the gaps in current literature.

Connection to Current Literature

The connection to current literature is slightly challenging in that there is little to no specific research incorporating the lived experiences of PM Christian women's mental, emotional, and spiritual health. There is an abundance of literature focused on medical, personal, self-help, and mental health related to PM; however, there are inconsistencies (e.g., stages of menopause, length of time, ages, treatments). Quantitative studies on PM and menopause are numerous; however, qualitative studies focused on women's lived experiences during PM are missing. Considerable information is available on medications to treat the symptoms of PM such as antidepressants to treat depression, anxiolytics to treat anxiety, estrogen, and hormone therapy to treat hormonal imbalances; however, there is less information on other forms of treatment such as natural remedies or supplements, homeopathic, holistic, counseling, exercise, or spirituality. Several participants discussed how medications were recommended but later opted for other forms of treatment to manage their symptoms (e.g., natural remedies, exercise, dietary changes, counseling, spiritual interventions).

Regardless of the limited literature, the present study on the lived experiences of PM Christian women connected to findings from the current research concerning the bio-psycho-social-spiritual aspects of PM (as compared to the other stages of menopause), challenges women face during PM, coping mechanisms utilized and protective factors, and the stigma experienced by PM women. According to the literature, women will endure the most physiological changes that can have a direct impact on biological and psychological functioning, during PM (Delamater & Santoro, 2018; Gibbs et al., 2013). The reason for such dynamic changes is due to variations in hormone (i.e., estrogen, progesterone, testosterone) levels, which

may lead to physical symptoms and emotional instability (Bromberger et al., 2001; Delamater & Santoro, 2018; Elavsky, & McAuley, 2007; Gordon-Elliot et al., 2017; Mauas et al., 2014; Sandilyan & Dening, 2011; Treloar, 1981). Therefore, without proper treatment, coping strategies, and support, quality of life is negatively impacted (Delamater & Santoro, 2018; Elavsky, & McAuley, 2007; Frey et al., 2013; Gibbs et al., 2013; Hunt, 2016; Levin, 2015; Mauas et al., 2014; Pagán, 2018; Sandilyan & Dening, 2011; Terauchi et al., 2013; Woods & Mitchell, 2011; Worsley et al., 2014).

Bio-Psycho-Social-Spiritual Aspects of PM

The bio-psycho-social-spiritual model provides a conceptual background for clinicians to understand their clients' lived experiences, granting a more holistic approach for treatment in the realm of mental health and greater quality of life (Engel, 1997; Koenig, 2012; Porter, 2020; Saad et al., 2017). Physical and mental health can be interconnected as physical symptoms can mimic mental health issues and vice versa; therefore, clinical mental health counselors must be cognizant of their clients' presentation to determine the next steps for treatment (Jagtap et al., 2016; Kanadys et al., 2016; Wariso et al., 2017). The inclusion of R/S enables the clinician to have a greater understanding of the client, which translates into more accurate approaches to diagnosis and treatment. R/S has varied meanings, both positive and negative, for people for various reasons; nevertheless, R/S offers connection with others and with God, personal meaning and purpose, wellness, an increased sense of self, enhanced self-esteem and self-worth, coping skills to reduce depressed mood or anxious feelings, and provide a sense of hope (Briggs & Dixon, 2013; Mohr, 2011; Yonker et al., 2012). Participants of this study confirmed these findings through their descriptions concerning the impact of their physical and psychological PM experience on their social and R/S functioning.

Results from this study were no different than the research, particularly in how physical and psychological PM symptoms impacted social and R/S functioning. Menopause, a normal biological process and major life event, affects millions of women globally (Grochans et al., 2018; Hunt, 2016; Kopciuch et al., 2017; Muslić & Jokić-Begić, 2016; Onder & Batigun, 2016; Sandilyan & Dening, 2011; Sharma & Mahajan, 2015; Steffen, 2011). PM or the MT, is an indicator for the end of fertility and can bring about biological and psychological changes that feasibly impact social functioning and spiritual growth (Delamater & Santoro, 2018; Elavsky & McAuley, 2007; Gordon-Elliott et al., 2017; Hunt, 2016; Kopciuch et al., 2017; Mauas et al., 2014; Muharam et al., 2018; Onder & Batigun, 2016; Rindner et al., 2017; Sandilyan & Dening, 2011; Sharma & Mahajan, 2015). Symptoms associated with menopause include physical (e.g., hot flushes, night sweats, muscle and joint discomfort), psychological (e.g., depressed mood, low energy, irritability, mood swings, and mental exhaustion), social (e.g., social withdrawal, avoidance, isolation), and spiritual (e.g., closer or more distant relationship with God; perceived feelings of guilt, shame, stigma from the R/S community), that if left unresolved result in diminished quality of life (Becker et al., 2007; Blackmore et al., 2008; Bromberger & Epperson, 2018; Bromberger et al., 2011; Bromberger et al., 2007; Delamater & Santoro, 2018; Elavsky, & McAuley, 2007; Flores-Ramos et al., 2018; Frey et al., 2013; Gibbs et al., 2013; Jagtap et al., 2016; Karkhanis & Mathur, 2016; Mauas et al., 2014; Pagán, 2018; Sandilyan & Dening, 2011; Sharma & Mahajan, 2015; Terauchi et al., 2013).

Challenges Women Face During PM

PM Christian are confronted with many challenges during this time in their lives such as physical and biological health issues and complications; psychological, emotional, mental, and cognitive difficulties; social, interpersonal, and relational strain; and R/S disruptions (Delamater

& Santoro, 2018; Elavsky & McAuley, 2007; Gordon-Elliott et al., 2017; Hunt, 2016; Kopciuch et al., 2017; Mauas et al., 2014; Onder & Batigun, 2016; Rindner et al., 2017; Sandilyan & Dening, 2011). In addition to the bio-psycho-social-spiritual changes, PM Christian women are confronted with challenges related to their self-identity or self-perception (Sergeant & Rizq, 2017). Lastly, another challenge PM women face is barriers associated with obtaining the right information on PM and menopause to make informed decisions about their treatment (Losinski et al., 2021). In the present study, all participants shared their struggles with negative symptoms of PM, shifting perceptions with their self-identity, and several participants discussed issues they faced in either not knowing about PM or difficulties obtaining information on PM.

Bio-Psycho-Social-Spiritual Challenges. PM women are more likely to experience the most physiological changes than women who are pre- or postmenopausal (Delamater & Santoro, 2018; Gibbs et al., 2013). These physiological changes have a profound impact on physical and mental functioning during PM that can also affect social functioning and may interrupt R/S participation as was evidenced from some of the findings from this study. Participants reported there were times when they were too tired, had low energy, and experienced poor concentration that resulted in interruptions in their R/S practices. Additionally, findings also showed that some participants self-isolated and withdrew from previous friend groups, confirming previous findings (Frey et al., 2013; Sandilyan & Denning, 2011; Sharma & Mahajan, 2015).

Challenges with Self-Identity or Self-Perception. A woman's sense of identity is socially constructed and established through interpersonal interactions with others (Sergeant & Rizq, 2017). In this study, participants expressed both positive and negative challenges they faced with their self-identity and self-perception. Consistent with previous findings, some participants of this study expressed looking forward to this new phase in their lives (e.g., not

having to worry about pregnancy, shift in caregiving roles, taking on additional roles; Harper et al., 2022). Nevertheless, many participants expressed negative thoughts, feelings, and experiences due to their physical and psychological PM symptoms that influenced their self-perception, self-esteem, and self-worth leading to self-isolation or severely limiting their social interactions or interrupting their R/S engagement, which is also consistent with previous findings (Beutel et al., 2009; Harper et al., 2022).

Further, for PM Christian women who have a close connection with marriage and family, the inability to have their own children can result in guilt and shame (Steffen, 2011). Consequently, self-identity may be negatively affected in how she views herself as a woman or how she believes others see her as a woman, wife or partner, which could lead to emotional suffering and relational problems (Gordon-Elliott et al., 2017). Despite this, menopausal symptoms were shown to decline for women who engaged in their R/S, and provided them with a sense of peace, purpose in life, and ability for self-forgiveness and forgiveness of others (Steffen, 2011). Consistent with the literature, this study revealed some participants embraced this new phase in their lives, whereas other participants had negative reactions. Younger participants that were unmarried appeared to have the most distress about being in PM.

Obstacles Procuring Information. Study findings concur with related literature regarding the obstacles women face in obtaining adequate information on PM and menopause, leaving them uniformed and unprepared to make critical healthcare decisions (Grose, 2021; Harper et al., 2022; Losinski et al., 2021). According to the literature, many women lack knowledge on PM and do not have a clear understanding of their PM symptoms in addition to an absent or limited support system of friends, family, or healthcare professionals (Grose, 2021; Harper et al., 2022; Losinski et al., 2021; National Institute on Aging, 2022). Education on

menopause in many of the American obstetrics and gynecology training programs are significantly lacking considering women will spend one-third of their lifetime in postmenopause due to increased life expectancy (average 84 years; Carcelén-Fraile et al., 2020; Hunt, 2016; Sharma & Mahajan, 2015). The Menopause Society (2023) argued that due to the absence of uniformity in menopause education, medical school residents may not have the tools necessary to offer proper care for menopausal patients as a customary level of care does not currently exist. Many PM women are left feeling unsupported, abandoned, dismissed, misdiagnosed, and confused by healthcare professionals due to their lack of awareness or knowledge about PM and menopause (Harper et al., 2022). Additionally, information on PM and menopause is not always readily accessible for some women, as evidenced by some of the findings of this study. This leaves women frustrated, feeling dismissed or overlooked, and discouraged (Harper et al., 2022).

Coping Mechanisms Utilized and Protective Factors

Coping mechanisms and protective factors are invaluable to decrease stress, relieve symptoms of depression or anxiety, reduce the effect of challenges that adversely affect well-being, and enable a person to positively adjust when faced with problematic situations or circumstances (Millacci, 2017; Wilson, 2021). Coping strategies and protective factors come in many different forms and are unique to the individual. Coping mechanisms are either healthy (positive) or unhealthy (negative). Healthy coping skills include management of emotions, social support, increased communication, hobbies, prioritization of self, delegation of authority, self-care, while unhealthy coping skills consist of abusive behaviors, addiction, avoidance of problems, self-harm, isolation. Protective factors empower the individual to make affirmative modifications when confronted with troublesome situations or circumstances to regulate emotions, find meaning, and foster interpersonal growth (Wilson, 2021). Protective factors can

include emotional awareness, emotional regulation, one's purpose in life, R/S, family involvement and attachment, and supportive social relationships. Findings of this study endorse the assertions made by previous researchers concerning positive and negative coping and protective factors validated the significance of possessing positive coping and protective factors to manage the negative symptoms of PM (Millacci, 2017; Wilson, 2021).

R/S were discussed as part of this study. Most participants relied on their faith or found comfort in increased spiritual growth during PM, which is consistent with the current literature on R/S in coping with a variety of physical and mental health issues not specifically related to PM. R/S was shown to provide or improve interpersonal connections with others and with God, add meaning and purpose to one's life, increase wellness, and improved sense of self-esteem and self-worth (Briggs & Dixon, 2013; Livingston & Cummings, 2009; Mohr, 2011; Yonker et al., 2012). Additionally, R/S coping was found to offer encouragement, guidance, reassurance, and empower women through a sense of positive well-being. Women who engage privately in nontraditional or "solitary spiritual activities" such as meditation, prayer, communing with nature, or listening to music, have reported improved mental health (Koenig, 2010; Livingston & Cummings, 2009). This is consistent the with findings of this study for participants who actively engaged in their spiritual growth during PM.

Findings from this study concur with the research in that participants' physical, biological, psychological, emotional, mental, and cognitive PM concerns impacted their social, relational, and R/S functioning; however, the level of impact varied from one participant to the next based on coping mechanisms, protective factors, and severity of PM symptoms experienced. However, real-world applications, particularly R/S interventions, specific for the treatment of depression, anxiety, bipolar disorder, and other mood instabilities associated with PM, are

significantly deficient (Pimenta et al., 2014; Steffen, 2011). A person's core belief system is guided by R/S identity and helps shape an individual's overall worldview. This worldview influences how someone comprehends the world, how to cope during difficult circumstances, understand mental and physical illness, and themselves (Brandt et al., 2009; Milner et al., 2020; Oxhandler et al., 2018; van Nieuw Amerongen-Meeuse et al., 2021). Nevertheless, some participants of this study relied on their Christian faith as a means for coping, which corroborates the assertion that spiritual coping skills are necessary in the recovery process and life satisfaction (Beutel et al., 2009; Milner et al., 2020). It should be noted; however, that challenges can be experienced when R/S is adversely affected (e.g., interruption in R/S practices or attendance at R/S services or events; feelings of guilt, shame, and stigma from the R/S community) by negative mental health symptoms (e.g., depressed mood, low energy, concentration problems).

Stigma Experienced by PM Women

Findings from this study confirmed what has been discovered in the current literature in that participants shared they were not told about PM or menopause. GenX or GenXers (aged 43-58 years) were not exposed to many positive portrayals of PM or menopause in popular culture; rather, PM or menopause described as a very negative time in a woman's life and that "life was now over" for her (Harper et al., 2022; Sergeant & Rizq, 2017; see also Finestra et al., 1999; Hanalis et al., 1981; Harris & Hughes, 1986; Lear et al., 1972; Turner et al., 2002. Additionally, women were illustrated as highly emotional, aggressive, and unable to perform, and made to feel old or useless (Finestra et al., 1999; Hanalis et al., 1981; Harris & Hughes, 1986; Lear et al., 1972; Turner et al., 2002). Participants of this study confirmed how this view influenced how they looked at PM or menopause prior to their own PM and how they viewed themselves in PM. Without open discussion of PM and menopause, negative discourse and perception from others

only continues. The promotion of positive, dynamic, attractive, and successful PM or menopausal roles models decreases when negative beliefs about PM and menopause are not rectified; this is especially the case in countries where elder women are not appreciated for their age, wisdom, and place in the family (Sergeant & Rizq, 2017). However, positive descriptions of PM and menopause are on the rise as celebrities use their platform to speak out regarding their experiences with PM (see Cox, 2022; Fadal, 2023; Holohan, 2023; Kapital Entertainment, 2022; King, 2010). The stigma of PM and menopause will continue if the discourse does not change; therefore, it is important that these conversations take place between women, men and women, and women and their support systems.

Expansion on the Current Literature

As mentioned, research on the lived experiences of PM Christian women is quite limited. There is copious amounts of literature on the subjects of PM, menopause, physical and psychological symptoms of PM and menopause, existential health psychology (not related to PM or menopause), and the effects of R/S coping on physical and mental health (not related to PM or menopause). But there is limited literature associated with PM or menopause. Most of the literature concentrates on quantitative studies or meta-analyses of many studies, which should never be ignored or dismissed as the information garnered from these studies and meta-analyses are important to women's physical and mental health. However, women's voices need to be added to the conversation.

Integration

This study integrates the physical, biological, psychological, emotional, mental, cognitive, social, relational, interpersonal, and R/S factors that positively or negatively impact PM Christian women, while highlighting coping and protective factors, and shares their lived

experiences to expand on the current research. This study fills the research gap in that PM Christian women's lived experiences are being documented and shared; however, the findings cannot be generalized with the larger population of PM Christian women at this point without further investigation, which will be discussed in the Implications section of this chapter. But the stories that were shared by participants of this study may resonate with some PM Christian women in the larger community and they will identify with participants' experiences, particularly for women who do not fit what is documented in the current literature.

Women Who Fit Outside of Current Documented Literature

Much of the research on PM indicates PM begins in a woman's late 30s; however, there were participants of this study who shared they entered PM at earlier ages, much to their surprise (Bromberger et al., 2018; Delamater & Santoro, 2018; Elavsky, & McAuley, 2007; Gordon-Elliott et al., 2017; Mauas et al., 2014; Nall, 2021; Sandilyan & Dening, 2011). Due to this unexpected turn of events, these participants also must reevaluate and make critical decisions about their future (e.g., adjust expectations about the future, relationships, perception of self). In the case of one participant of this study, she had to seek consultation with several doctors before any tests were performed to confirm or rule out PM. Due to the lack of a standardized menopause education program in medical schools, residents are not always equipped with the necessary tools to provide appropriate care to menopausal patients; therefore, patient complaints can often be dismissed and misdiagnosed, leaving women in a vulnerable position (Harper et al., 2022; The Menopause Society, 2023).

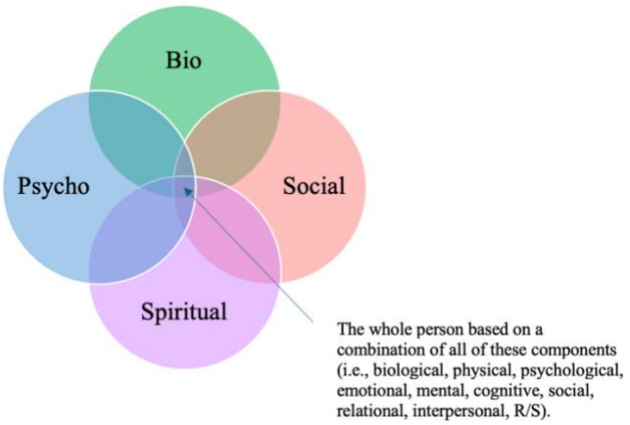
Association to the Theoretical Framework

A key characteristic of this study was the examination of the bio-psycho-social-spiritual model in relation to PM Christian women's lived experiences. Findings discussed the biological,

physical, psychological, emotional, mental, cognitive, social, relational, interpersonal, and R/S components of each participant's PM experience. PM and menopause are not just physical experiences; therefore, a more holistic approach is necessary for treatment that can lead to a better quality of life (Engel, 1997; Koenig, 2012; Porter, 2020; Saad et al., 2017). The following figure illustrates how the bio-psycho-social-spiritual model, combined, makes up the whole person to bring the human element into the purview of the scientific domain.

Figure 9

The Whole Person: Bio-Psycho-Social-Spiritual Model



Further, the purpose of a feminist theoretical framework in this study was to make known the continued existence of systemic oppressive mindsets and eliminate these unfair perceptions; reveal areas for change, bring awareness to, and promote viable solutions to assist PM Christian women in their physical and mental healthcare; and to empower PM Christian women to communicate their experiences (Arinder, 2020; Brabeck & Brown, 1997; Disch & Hawkesworth, 2016; McCann & Kim, 2017). According to feminist theorists, notwithstanding more recent efforts to build up awareness of women's physical and mental health during PM, persistent patriarchal control and attitudes about women, their health, and their position in society, remain an everlasting problem in the medical field, and continue to leave women's health concerns

behind (Enns, 2004; Hennessy, 2014; Kantola, 2016; Weedon, 2003). In this study, participants discussed the struggles they experienced in PM related to their bio-psycho-social-spiritual functioning, challenges they experienced with obtaining appropriate medical care or PM education, and their apprehension at the uncertainty of what is happening with their bodies because of their lack of knowledge of PM. In the four waves of the Feminist Movement from the late 19th century to present day women have fought for equal rights to vote, access to healthcare, safe workplace environment, inclusion, respect, and to be seen as humans.

Extension of the Theoretical Framework

This study extends the theoretical framework by highlighting the unique needs of PM Christian women. The bio-psycho-social-spiritual model emphasizes specific issues PM women experience that are different from women who are in pre- or postmenopause, female or male adolescents, or men. For example, during PM, women will experience the most physiological symptoms than the other phases of menopause, which can substantially impact PM women's overall functioning (Delamater & Santoro, 2018; Gibbs et al., 2013). From this standpoint, it is essential to consider all factors of bio-psycho-social-spiritual functioning and how each piece of this model directly impacts the next. As substantiated by the findings of this study, participants reported how their physical functioning (e.g., irregular menstrual cycle, sexual dysfunction, insomnia) affected their mental or cognitive functioning (e.g., irregular mood, depression, anxiety, forgetfulness), thus affecting relational functioning (e.g., relationship difficulties, self-isolation, withdrawal) and R/S functioning (e.g., interruption of R/S engagement). Furthermore, self-identity was also affected as many participants expressed a shift in how they perceived themselves. The following illustration demonstrates how each part of the bio-psycho-social-spiritual model builds on the next, thus creating a cycle.

Figure 10

How the Bio-Psycho-Social-Spiritual Model Becomes a Cycle

In addition to the bio-psycho-social-spiritual model, the aim in utilizing a feminist theoretical framework for this study was to highlight how antiquated ideas, silence, limited accessibility of information, and ill-prepared healthcare workers continue to perpetuate the negative perception of PM. Over time, feminist theory has evolved from focused attention on the end of oppression of women to the end of oppression of any marginalized person or group (Arinder, 2020, Brabeck & Brown, 1997). Feminist theory seeks to spotlight where change is needed, bring awareness, eliminate discriminatory perceptions, foster practical solutions, and encourage and empower marginalized populations (Arinder, 2020; Brabeck & Brown, 1997; Disch & Hawkesworth, 2016; McCann & Kim, 2017). This study demonstrated the need for increased PM education through support groups in both R/S or secular settings; increased PM and menopause education through the medical community and mental health community; increased communication between women, women and their support systems, women and men, and the importance of sharing with up-coming generations of women their PM experiences; and to normalize the conversation of PM and menopause in general and in the R/S realm. Hence, a bio-psycho-social-spiritual was combined with feminist theoretical framework (see Figure 11). Additionally, principles of feminist theory are illuminated to show where change is needed, to

provide practical solutions and avenues for increased awareness, expose discriminatory perceptions or practices, and encourage and empower PM and menopausal women (Arinder, 2020; Brabeck & Brown, 1997; Disch & Hawkesworth, 2016; McCann & Kim, 2017).

Figure 11

Interconnections of Coping Skills and Protective Factors with the Bio-Psycho-Social-Spiritual Model with Practical Applications of Feminist Theory Principles

Implications

The implications of this study are carried over theoretically, empirically, and practically. The following sections will provide a discourse on the theoretical implications this study had on the bio-psycho-social-spiritual model of functioning as well as feminist theory. Empirical implications are discussed in how this study's findings impact the various fields of physical, mental, social, and R/S health. Lastly, practical implications will specifically detail how these various healthcare and R/S entities, along with educational programs, can assist PM Christian women, increased communication on PM and menopause, open up the conversation on PM and menopause, and end the stigma associated with PM and menopause.

Theoretical Implications

The bio-psycho-social-spiritual model of functioning can be combined with feminist

theory to provide a model that describes PM Christian women's overall physical, emotional, relational, and R/S functioning, while also demonstrating how feminist theoretical principles identify areas for needed change, offer sensible solutions to enable PM women to get the support and education they need to make informed decisions, increase consciousness of the needs of PM Christian women to gain support, confront and end practices that stigmatize PM Christian women, and encourage and empower PM and menopausal Christian women (Arinder, 2020; Brabeck & Brown, 1997; Disch & Hawkesworth, 2016; Engel, 1997; Koenig, 2012; McCann & Kim, 2017; Porter, 2020; Saad et al., 2017). Understanding the influence of coping skills and protective factors on bio-psycho-social-spiritual functioning will allow for greater understanding for the needs of PM Christian women as well develop appropriate treatment and support protocols. Further study is needed to provide a more comprehensive understanding of the specific needs of PM women outside of the United States, non-Christian women, and women who had surgical interventions that ended their menstrual cycles.

Empirical Implications

Empirical findings of the current study, centered on the themes argued in Chapter 4, enlighten the medical, mental health, psychology, sociology, community and family care, R/S care and support, pastoral and lay counseling, and advanced studies education in clinical mental health counseling. The implications of the current study are anticipated to influence how PM Christian women receive service provision.

Practical Implications

Practical implications of this study offer approaches for various entities that work with PM Christian women. These could involve the counseling and mental health profession, the medical profession, family resources and community care, R/S care and support, pastoral and lay

counseling, and advanced studies education. Multidisciplinary efforts can also impact bio-psycho-social-spiritual functioning by enlisting a team of providers in collaboration with the client and their support systems to assist the client to greater well-being (Nagle-Yang et al., 2023).

Implications for the Counseling Profession

According to the *2014 ACA Code of Ethics* (2014), counseling is defined as a professional relationship between a clinical mental health counselor and client (e.g., individual, family, group) for the express purpose of improved mental health, greater well-being, psychoeducation, and attainment of career goals. This is achieved through focused attention to human development; increased diversity; implementation of a multicultural approach that promotes worth, dignity, potential, and individuality; social justice; veracity of the therapeutic relationship; and competent and ethical practice. Based on the current literature and the findings of this study, PM Christian women need support to better understand what is happening in their bodies to traverse the PM journey successfully. PM can be a difficult journey for some women, particularly when they are not aware of what they can expect, which can be scary and mysterious, as attested by participants of this study. The aim of this study is to provide the building blocks for those working with PM Christian women, their families, and other service organizations to support the unique needs of this population. Further research is needed; however, a training for counselors specific to the needs of PM Christian women could benefit mental health counselors to understand the physiological changes that PM experience or might experience, as well as address mental health challenges, self-identity issues, and role transitions, among other issues. As mentioned in the findings of this study, self-image, self-esteem, self-worth, and confidence are directly affected by the physical and emotional changes that

participants experienced due to PM.

Individual Counseling. As previously discussed, psychological, mental, emotional, and cognitive issues are quite common during PM, particularly due to hormonal fluctuations (Delamater & Santoro, 2018; Elavsky & McAuley, 2007; Gibbs et al., 2013; Hunt, 2016; Levin, 2015; Mauas et al., 2014; Pagán, 2018; Pearson, 2010; Sandilyan & Dening, 2011; Terauchi et al., 2013; Woods & Mitchell, 2011; Worsley et al., 2014). Common mental health concerns related to PM involve emotional instability, irregular mood, depressive mood, anxiety, cognitive deficits, forgetfulness, hostility, and confusion. Moreover, some women can be at a heightened risk for reoccurrence of, or initial onset of, major depressive disorder (Becker et al., 2007; Blackmore et al., 2008; Bromberger & Epperson, 2018; Bromberger et al., 2007; Delamater & Santoro, 2018; Gibbs et al., 2013). However, based on the findings of this study, participants reported a higher incidence of anxiety. Regardless, mental health counseling enables PM women to discuss their experiences, changes in self-identity, shifting roles, and gains and losses experienced. Mental health counseling also provides psychoeducation, evidence-based interventions, lifestyle interventions, addresses cognitive issues, body image and sexual health, and encourages conversation and empowerment to end the stigma of PM and menopause (DeAngelis, 2023).

Changes in Self-Identity. For many PM Christian women, self-identity is affected during PM, either positively or negatively. For those who are closely tied to family, the inability to bear children can result in feelings of guilt and shame (Gordon-Elliott et al., 2017; Steffen, 2011), though R/S oriented women have reported a greater sense of peace, life purpose, and forgiveness (Steffen, 2011). Findings for this study confirmed previous research in that self-identity was tied to the ability to have children for some participants; nevertheless, other participants shared that

they experienced new freedoms (e.g., independence) and saw PM as a new chapter in their lives. Self-identity was also tied to changes in abilities for some participants of this study in that low-energy, fatigue, cognitive issues, and mental health challenges limited their participation in typical daily activities (see Sergeant & Rizq, 2017).

Shifting Roles. In addition to the physiological and mental health changes that can accompany PM, major life transitions also occur such as shifting roles one plays in the family (DeAngelis, 2023). Additionally, as mentioned in this study, changes in employment status also occur such as opening a business. Similarly expressed in this study, participants shared how their roles have shifted as their children get older, become more independent, and leave home for college. Other roles changes reported by participants include becoming grandparents, making friends with people not associated with their kids, and taking care of aging parents or coping with the loss of elderly parents (see Bromberger & Epperson, 2018).

Gains and Losses Experienced. As previously stated, the literature, as well as popular culture, details physical and psychological challenges that occur during PM and discuss how these challenges impact social and R/S functioning; however, it is important to take notice of the advantages of PM and what benefits can be taken advantage of during this time (DeAngelis, 2023; Delamater & Santoro, 2018; Elavsky & McAuley, 2007; Gordon-Elliott et al., 2017; Hunt, 2016; Kopciuch et al., 2017; Mauas et al., 2014; Onder & Batigun, 2016; Rindner et al., 2017; Sandilyan & Dening, 2011). Several study participants expressed feelings of depression, anxiety, being scared, uncertain, or down because of the PM symptoms they were experiencing and did not fully understand. Other participants chose to take a more positive approach in that they saw PM as a new chapter, new freedom, independence, an opportunity to focus on themselves more, and take charge of their health.

Counselors Outside of the PM Mold. There are many counselors who do not fit the PM mold, nor will they ever fit that mold (e.g., male counselors, gender-diverse counselors); however, male counselors or gender-diverse counselors can provide support services to PM and menopausal women in an ethical and culturally sensitive manner through appropriate training. Training could involve reading trustworthy materials on the topic of PM and menopause, consulting with a medical professional or another mental health professional that specializes in PM, or taking a class on PM. The counselor's job is to support the well-being of their clients throughout the life span, which means assisting clients with developing tools and means for coping to pilot their PM journey, thus building the foundation for a successful postmenopausal experience that could last for decades (Carcelén-Fraile et al., 2020; DeAngelis, 2023; Hunt, 2016; Sharma & Mahajan, 2015).

Marital and Family Counseling. Psychoeducation is important in all areas of the counseling experience; however, psychoeducation has greater importance in marital and family counseling (DeAngelis, 2023). Women and men must understand that menopause is a natural biological process and not internalize the effects of PM as a personal attack on or from the other person. It is important for mental health counselors, especially those who see couples in midlife, to be aware of how the symptoms of PM can affect women and consequentially affect the marital relationship. Some participants of this study shared how their marital relationships were affected due to sexual dysfunction or emotional issues that escalated to arguments.

Group Counseling and Support Groups. As mentioned by several participants of this study, group counseling or support groups specifically focused on PM would be especially beneficial to help them understand their symptoms and for them to know they are not alone in their PM journey. Some participants expressed feeling alone, rejected, or misunderstood by

social support, thus further perpetuating noncommunication about PM, which led to guilt and shame for these participants. Social/support group participation can assist PM women move through this phase in life successfully (Arnot et al., 2021; DeAngelis, 2023; Naworska et al., 2020).

Implications for the Medical Profession

Research indicated a deficiency of dedicated instruction on the topic of PM and menopause in American obstetrics and gynecology medical school programs (Allen et al., 2023; Christianson et al., 2013; Krewson, 2023; Naidorf, 2023; Open Access Government, 2023; The Menopause Society, 2023). Due to the absence of formal menopause education, nor a traditional level of care concerning menopausal patients, appropriate care is restricted (The Menopause Society, 2023). As a result, PM women are left feeling unsupported, abandoned, dismissed, misdiagnosed, and confused by healthcare professionals due to their lack of awareness and knowledge on PM (Harper et al., 2022). Supervised clinics, case presentations, formal lectures, small groups, web-based learning, and independent or self-paced study are needed to increase their knowledge on menopause (Allen et al., 2023; Christianson et al., 2013; Krewson, 2023; The Menopause Society, 2023). Furthermore, a 2-year menopause instruction program to include lectures and case studies for OB/GYN residents can be an effective tool to increase knowledge needed for treating PM and menopause (Christianson et al., 2015).

Women's health research has also been historically underfunded and ineffectively researched as treatment recommendations are based on men's bodies. Participants in the current study shared that they have done their own research into PM, have attempted to do some research into PM, or were unable to obtain needed information on PM. Continued research is needed to determine appropriate methods of instruction and dissemination of menopause

education in medical school environments. Research is also needed concerning conditions that impact women of color as well as women with disabilities. Thus, in November 2023, the White House Initiative on Women's Health Research was announced to provide more research and funding specifically for women's health (Harter, 2024; The White House, 2024c). On March 18, 2024, President Biden signed an Executive Order on Advancing Women's Health Research and Innovation (The White House, 2024a).

Implications for Family Resources and Community Care

As mentioned, the White House Initiative on Women's Health Research was announced on November 13, 2023, thanks to the efforts of First Lady, Dr. Jill Biden and the White House Gender Policy Council (The White House, 2024b). President Biden requested the U.S. Congress to approve $12 billion in funding for the initiative. This funding can impact many facets of women's healthcare to include family resources and community care (e.g., behavioral health services, services for the homeless, HIV services for PM and menopausal women, lab services for women, primary care services for menopausal women, social welfare services, in home care, nursing services).

Implications for R/S Care and Support and Lay Counseling

Many R/S communities offer some type if care and support for their parishioners such as lay counseling, pastoral counseling, support groups, recovery groups, or prayer ministry depending on the size and needs of the church. According to The Lay Counseling Institute, lay counselors are non-ordained members of the church community that have been spiritually called to care for the needs of others in the spiritual community (Walkley, n.d.). Lay counselors are volunteers and provide lay counseling services under the direction of their local church (e.g., church leadership, professional counselors). Lay counselors are not required to obtain

professional licensure from their state; however, they are trained and supervised by licensed professionals and adhere to the same guidelines for confidentiality and privacy as professional counselors (Walkley, n.d.). The role of the lay counselor is to provide biblical guidance and God's truth to process difficult seasons in life, promote healthy relationships, encourage behavioral change if needed, develop healthy coping strategies, and provide support and guidance on decision making or problem solving (Community Bible Church, 2024; Walkley, n.d.). Some of the participants of this study expressed an interest in their church providing some type of support for PM and menopausal women. Further research into churches and R/S organizations is needed to implement such a program for PM and menopausal women. Furthermore, offering this type of service in R/S environment may be useful to the women served, destigmatize discussion of PM and menopause, and open the conversation of PM and menopause.

Implications for Counselor Education and Supervision and Clinical Mental Health Counseling Education

There are many counselor education programs throughout the world whose students could specifically benefit from menopause education and practice. Detailed lessons in menopause education could be added to the human growth and development class or a special topics course could be developed and offered to counseling students interested in working with PM and menopausal women. As mentioned, medical school curriculum specific to menopause education is severely lacking. PM and menopause are not just physical issues with no deportment on psychological, cognitive, social, or R/S well-being. Counselor education is also needed for working with PM Christian women.

Counsel for Accreditation of Counseling and Related Educational Programs. The

Counsel for Accreditation of Counseling and Related Educational Programs (CACREP) is an organization that provides accreditation to qualifying graduate degree-specific programs in counseling (CACREP, 2024b). For a program to qualify for accreditation, a self-assessment and a peer-assessment are conducted. A self-assessment is created and developed by program administrators and clearly outlines the mission, goals, and objectives for that program, as well as a review of the resources, strengths, and limitations of that program for the purpose of improved educational efficacy. This information is made available to the public to promote transparency and accountability of program practices and enables students to make the most informed decision when choosing a clinical mental health program for their course of study (CACREP, 2024b).

Peer evaluation allows for the opportunity of selected advisers (e.g., counselor educators, professional counselors, individuals from the community representing the public interest) to examine the scholarly merit and professional rigor of the counseling program based on appropriateness of the curriculum, facilities, faculty, and students. Advice and counsel are given during an onsite review, as well as verbal and written feedback. This information is then incorporated into the counseling program's future plan for the purpose of scholastic improvement (CACREP, 2024b).

To avoid opposition among the various educational programs, graduate-degree programs are not ranked alongside one another. CACREP strives to promote an open exchange of research and transformation within the wider counseling academic community. There are five professional roles addressed in a counselor education program counseling, supervision, teaching, research and scholarship, and leadership and advocacy (CACREP, 2024a). The following sections will detail the applicability of incorporating PM and menopause education into a counselor education program based on the five professional roles mentioned above based on the

2024 CACREP Standards (2024a).

Counseling (6.B.1). As part of the professional role of counseling, under CACREP Standards (2024a), there are six principles that are necessary of counselor education graduates. The first principle (a) requires a scholarly analysis of evidence-based theories and practices beneficial to working with PM or menopausal Christian women, followed by the integration (b) of applicable theories and practices in counseling PM or menopausal Christian women. Next, students are to demonstrate, through various theoretical orientations, case development and conceptualization (c) of several PM or menopausal Christian female clients. Careful consideration to cultural sensitivity (d) in the provision of counseling practices with PM or menopausal women is studied, which includes diverse settings, situations, environments, and through various service provision modalities. Students are to identify and develop procedures for assessing counseling efficacy (e) with PM and menopausal women. Lastly, legal and ethical considerations (f) and obligations in the delivery of PM or menopause counseling within various settings and through various service delivery methods are considered (CACREP, 2024a).

Supervision (6.B.2.). Included in the professional role of supervision, under CACREP Standards (2024a), are 12 criteria that are fundamental for counselor education graduates. Students should understand the utility (a), theoretical frameworks (b), and models of counseling supervision, as well as roles (c) within the supervisory relationship. Counselor education programs provide skills (d) necessary for the provision of supervision within various settings and service modes. Substantiated by theory and research, students are allowed the opportunity to develop their unique style (e) of counseling supervision. Future counselor educators learn and understand how assessment of supervisees' (f) level of development, among other characteristics, are vital in the overall disposition of an effective counselor. Different types (g) of

supervision are explored such as individual, triadic, and group supervision along with best practices of each. Utilization of technology (h), administrative procedures (i) and supervisor responsibilities such as evaluation (j), remediation, and gatekeeping, in addition to legal and ethical issues (k) and obligations are covered in counselor education programs and are of vital importance (CACREP, 2024a). Finally, cultural sensitivity in the supervisory relationship is covered. Relevant to working with PM and menopausal women, counseling supervisors can provide PM and menopause education and supervision to supervisees to gain a greater sense of understanding and empathy for the needs of their clients during this phase in their lives.

Teaching (6.B.3.). Comprised in the professional role of teaching, under CACREP Standards (2024a), are 13 conditions that are fundamental for counselor education graduates. Prospective counselor educators learn about the roles and responsibilities (a), methods and practices of adult learners (b), teaching methods (c), curriculum design and distribution, and the appropriate use of technology (e) associated with teaching new clinical mental health counselors. Important to learning about the needs of working with PM and menopausal clients is the amalgamation of diversity, equity, inclusion, and social justice (f) in counselor education, which follows in the comprehensive design (g) of the learning materials to satisfy individual differences in learning for all students. Upcoming counselor educators gain knowledge in evaluative (h) methods in teaching, assessment (j) of student knowledge and professional dispositions, legal and ethical (k) concerns in counselor education, culturally sensitive (l) approaches in counselor education, and the function of mentoring (m) in counseling education (CACREP, 2024a). In the provision of counselor education, graduate students learn about the specific needs of PM and menopausal women through the bio-psycho-social-model of functioning to have a greater understanding of the overall effect of PM symptoms and the various avenues for effective

treatment.

Research and Scholarship (6.B.4.). Involved in the professional role of teaching, under CACREP Standards (2024a), are 13 benchmarks that are central for counselor education graduates. These standards include knowledge and understanding of quantitative, qualitative, and mixed method research designs (a); methods and approaches relevant to quantitative (b) and qualitative (c) data analysis; sampling (d) methods based on research design; instrument design (e); and program evaluation (f). Additionally, students learn to create and develop appropriate RQs or hypotheses (g) in professional research; cultivate professional writing skills for journal publication (h), professional conference (i), IRB (j), or grant (k) proposal submissions. Lastly, cultural competence (l) in research practices and considerations for ethical (m) matters in research are paramount in counselor education research and scholarship (CACREP, 2024a). Research and scholarship concerning PM and menopause, especially research into R/S involvement in PM and menopause, are important to bring awareness, address needs of PM and menopausal Christian women, and educate counselors on how to better serve this population.

Leadership and Advocacy (6.B.5.). The professional role of leadership and advocacy, under CACREP Standards (2024a), are 14 targets that are significant for counselor education graduates. A part of leadership and advocacy is understanding the theories, models, and skills of effective leadership (a); leadership and development of leaders in the professional counseling organizations (b; e.g., federal, state, local) and counselor education programs (c); standards for program accreditation and processes such as self-studies and reports (d); knowledge of management and administrative duties in agencies, organizations, and other institutions (e); leadership roles and responsibilities during a crisis or disaster (f); and approaches to leadership in consultation (g). Future leaders and advocates need to be current on sociopolitical and social

justice issues and their effect on the counseling profession (h); and know appropriate competencies needed for advocating for the counseling profession and professional counselor identity (i) and for advocating for clients at all levels (j). Additionally, prospective leaders and advocates in the counseling profession need to understand the importance and value of diversity, equity, inclusion, social justice issues (k), and culturally sensitive approaches in leadership and advocacy practices (l); and adhere to ethical practices in leadership and advocacy (m). Lastly, it is imperative leaders in the counseling profession advocate and promote the practice of counselor self-care for colleagues as well as encourage self-care for clients (n; CACREP, 2024a).

Leadership and advocacy, as related to PM and menopausal Christian women, is lacking. Counselors, counselor educators, and counseling students can advocate for the needs of PM and menopausal Christian women through research, education, advocacy for women's health during menopause, and providing menopause education to other mental health providers. Table 6 highlights the 2024 CACREP Standards for Counselor Education and Supervision programs.

Table 6

2024 CACREP Standards for Counselor Education and Supervision Programs

Professional role	Standards
Counseling	Scholarly evaluation of evidence-based counseling theories and practice
	Incorporation of applicable counseling theories
	Case conceptualization from various theoretical orientations
	Cultural sensitivity in counseling practices in various settings, situations, and methods in the provision of service delivery
	Approaches for counseling efficacy
	Legal and ethical considerations and obligations
Supervision	Focus of counseling supervision
	Theoretical orientation and models of supervision
	Roles and connections within the supervisory relationship
	Supervision skills needed in various settings and service delivery methods
	Develop personal supervision style based on theory and research
	Evaluation and assessment of supervisee developmental level
	Types of supervision--Individual triadic, group
	Appropriate use of technology in supervision
	Administrative procedures and responsibilities
	Evaluation, remediation, and gatekeeping
	Legal and ethical considerations and obligations
	Culturally sensitive methods and approaches
Teaching	Roles and responsibilities of counselor educators
	Theories and approaches to adult learning
	Teaching methods and practices
	Curriculum development and development
	Appropriate use of technology in teaching design and delivery
	Incorporation of diversity, equity, inclusion, and social justice in curriculum
	Comprehensive design to meet the needs of all students with considerations for different learning styles
	Evaluative approaches in teaching
	Assessment, remediation, gatekeeping
	Appraisal of learning and professional dispositions
	Legal and ethical considerations and obligations
	Culturally sensitive methods and approaches
	Mentoring
Research and scholarship	Quantitative, qualitative, mixed method research designs, research questions, or hypotheses
	Quantitative and qualitative data analysis methods and approaches
	Sampling methods based on research design
	Program evaluation methods
	Appropriateness of research questions or hypotheses for professional research and publication
	Professional writing for journal publication or professional conference presentation proposal
	IRB proposal review
	Grant proposal funding
	Culturally sensitive methods and approaches
	Ethical considerations and method
Leadership and advocacy	Theories, models, methods, and skills of effective leadership
	Leadership and development of leaders in the professional counseling organiations and counselor education programs
	Standards for program accreditation and procedures such as self-studies and reports
	Management and administrative duties in agencies, organizations, and other institutions
	Leadership roles and responsibilities during a crisis or disaster
	Approaches to leadership consultation
	Awareness of sociopolitical and social justice issues and their effect on the counseling profession
	Know appropriate competencies needed for advocating for the counseling profession, professional counselor identity, and clients
	Understand the importance and value of diversity, equity, inclusion, social justice issues, and culturally sensitive approaches in leadership and advocacy practices
	Adhere to ethical practices in leadership and advocacy
	Advocate and promote the practice of counselor self-care for colleagues as well as encourage self-care for clients

Clinical Mental Health Counseling Programs. Graduate programs in clinical mental health counseling (CMHC) programs accredited by CACREP are required to provide foundational instruction in eight areas that represent compulsory knowledge for a masters-level graduate (CACREP, 2024a). These areas include professional counseling orientation and ethical practice, social and cultural identities and experiences, lifespan development, career development, counseling practice and relationships, group counseling and group work, assessment and diagnostic processes, and research and program evaluation. There are various opportunities within these guidelines where menopause education can fit. For example, menopause is a global phenomenon that affects millions of women worldwide; therefore, menopause education related to women from different cultures outside of the United States may benefit students' education experience. Menopause education would be especially important in lifespan development as menopause is a significant part of the lifespan, and women can spend up to a third of their lifetime in menopause. Career development is another area where menopause education can benefit counselors work with PM and menopausal women as they navigate the work environment and PM symptoms, along with other life situations. Counseling practice and relationships is important for working with not just PM and menopausal women but also their families and other support systems as PM and menopause do not only affect women. Group counseling and group work can be another benefit for PM and menopausal women as women can share their experiences, their highs and lows of their PM journey, and have a better understanding of their situations. Additionally, groups could also be held for PM and menopausal women's support systems (e.g., spouses, partners, adult children) to learn ways to be of better support for their loved one. Proper assessment and diagnosis is critical in the development of treatment practices in collaboration with the client, her family, and other

professional healthcare workers for an interdisciplinary approach. These are guided through research and program evaluation to determine how to best present menopause education in a graduate CMHC program (CACREP, 2024a).

Continuing Education Units. A vital aspect of professional counseling practice and a requirement for state licensure, continuing education units (CEUs) enable professional counselors to remain on top of current best practices with evidence-based treatments and techniques (National Board for Certified Counselors, 2024). CEUs can be obtained in a variety of different ways such as in-person, online, self-study, seminars, college courses, conference presentations, creation of a publication or presentation, and new program development. State licensing boards and counseling certification organizations (e.g., National Board for Certified Counselors, Association for Play Therapy, American Art Therapy Association, Certified Clinical Mental Health Counselor, National Certified School Counselor, Approved Clinical Supervisor) require yearly or bi-yearly documentation of a pre-determined amount of CEUs to remain licensed or certified and in good standing to continue ethical clinical practice. Although various treatment modalities (e.g., ACT, CBT, MBCBT) can be utilized to treat specific symptoms (e.g., depression, anxiety) of PM or menopause, there is little to no explicit CEU courses detailing PM or menopause education for professional counselors. Through further research, PM and menopause education for professional counselors that is culturally competent, ethical, and with evidence-based practices can be developed and provide much needed comfort for PM and menopausal women.

Demarcations and Limitations

For transparency, demarcations and limitations are identified and explored to provide a thorough understanding of the trustworthiness of the study findings and offer a direction for

future research. Demarcations and limitations are a common factor to all studies as the researcher may only desire to investigate a specific aspect of a particular phenomenon. The following sections will discuss demarcations and limitations of this study and the researcher's rationale for each.

Demarcations

Demarcations are boundaries set by the researcher or research team to define the parameters of the study. In Chapter 3, participant inclusion criteria were discussed (i.e., medical diagnosis or presence of PM symptoms by non-surgical means, identify as Christian, assigned female at birth, over 35 years of age). A possible weakness of this study is that many demographic characteristics were not taken into consideration or controlled for (e.g., race, ethnicity, sexual orientation, social class, education attainment, marital status, geographic location, children). In the current study, a purposive, criterion-based, and a convenience sampling method was used to secure a representative sample (Flamez et al., 2017; Moser & Korstjens, 2018; Patton, 2015; Peoples, 2021). Participants were selected based on their experience as PM Christian women and their openness to share their PM experiences. Of the participant sample, four participants were Black, two participants were Hispanic, and four participants were White. Participants resided mostly in the United States (i.e., California, Ohio, Pennsylvania, Texas, Virginia); however, one participant resided in Canada. The rationale for the lack of consideration for the demographic characteristics is that investigation of the lived experiences of PM Christian women is a relatively novel concept, therefore attaining a sample based on more specific qualifications would have been problematic.

Limitations

In the current study the lived experiences of PM Christian women were collected and

shared from the women who were affected by the experience. As mentioned, PM is indirectly experienced by family, friends, coworkers, and others in the support system. Data were not collected from spouses, partners, other family members such as children, and friends of the participants. Consequently, conclusions cannot be determined how PM affected the participants' marital relationship, family relationships, support networks, or occupational relationships. Data on race, marital status, mental health diagnosis, education attained, and geographic location were gathered for informational purposes only. Further study into those factors in addition to evaluating R/S involvement outside of Christianity is greatly needed for this population. Future research could include evaluating participants of one specific ethnicity, or a larger study could compare the differences among different races and ethnicities to determine appropriate treatment protocols that are more inclusive. Other areas for future study could include the effect of PM on previous mental health diagnosis or preexisting physical conditions.

Despite being a part of the inclusion criteria, age was not specifically controlled for in that the age range of the participants were 35-54 years of age. Furthermore, marital status and children were not considered or controlled for in this study. Based on the findings, it appeared that the younger, unmarried, and childless participants had a more difficult PM experience as opposed to participants that were older, married, and had children. Most of the participants who experienced PM at a younger age reported symptoms of depression and anxiety, emotional instability, irregular mood, and cognitive issues, along with physical PM symptoms such as headaches, hot flushes, insomnia, irregular menstrual cycle, night sweats, sexual dysfunction, and weight gain. Participants in their 50s had lower rates of depression but tended to experience the same rate of anxiety and cognitive difficulties as those participants in their 30s and 40s. Additionally, all participants reported having a good social support; however, younger

participants reported a higher rate of self-isolation and withdrawal that the participants in their 50s. PM studies specific to age, marital status, and children or no children could yield different results.

Recommendations

Based on the participant data collected and themes, recommendations can be made for PM Christian women. Recommendations can also be made for PM Christian women's significant support systems such as medical and mental health professionals, family, friends, partners, other relatives, and educational programs. The aim is for the recommendations to establish necessary services or provide needed improvement in services for PM and menopausal women with the goal of increased well-being. Furthermore, the hope is that these recommendations can also benefit those who support PM Christian women. In order for changes to be made, conversations need to happen, PM needs to be normalized and accepted as a reality in life, and treatments need to be geared toward improving the physical and mental health of PM Christian women.

Recommendations for PM Christian Women

One of the most frequent comments expressed by participants of this study consisted of the desire to want to know more about PM before their PM occurred. Most of the study's participants shared that they felt unprepared, surprised, scared, or uncertain when they first discovered they were in PM. They lacked the education and tools necessary to understand what they were experiencing physically in their bodies and psychologically in their minds. Their shock, surprise, or uncertainty came from different places. For example, younger, unmarried participants expressed the loss of their dream for marriage and children, while participants in their 50s found themselves slowing down, much to their disdain. Furthermore, another place

uncertainty may come from is in the lack of knowledge and understanding of PM and its varied symptoms. Participants expressed a desire for there to be more communication about PM and less stigma about PM. Various suggestions were given to increase communication about PM such as support groups, psychoeducational groups, doctors sharing PM information before onset of symptoms, opening the conversation to more than just PM Christian women to include men and others who support PM Christian women, and mentoring.

Another recommendation is to scrutinize the information gleaned from the internet as some resources are not as reliable as other sources. Dependence on the internet for healthcare information, while not ideal for some, may be the only thing available. There are a lot of well-meaning celebrities using their platform to raise awareness about PM as they were just as unaware of PM symptoms as many in this study. Therefore, it is important to use critical thinking when reviewing websites and the content of the information being produced. Questions women need to ask themselves when conducting PM research are shared in the following figure.

Figure 12

Critical Questions to Ask When Gathering Data Online

Finally, the participants of this study all identified as Christian. Many of these participants shared that they lean on their faith for guidance and comfort, as well as having supportive friends and family. Despite times when they reported having difficulty concentrating

on prayers or being too tired to pray, many in this study found engagement in their R/S rituals (e.g., prayer, Bible reading, biblical study, devotional reading) brought them comfort, sense of peace, and shifted their focus off their immediate situation.

Recommendations for Personal Support Systems

Personal support systems include family, friends, coworkers, extended family, and basically anyone who is not a professional that is there to support a PM Christian woman. Social support is important in anyone's life, but for PM Christian women, this is especially difficult as they are faced with possibly physically debilitating symptoms on top of feelings of depression and anxiety that they cannot quite explain. Furthermore, they may be more irritable or emotional for seemingly no apparent reason. Often self-isolation and withdrawal from others also occurs. Social supports could benefit from their own critical research and not being afraid to ask questions and provide a listening ear as necessary. Knowing there is someone there to listen can go a long way to helping someone through a difficult time.

Recommendations for Mental Health Counselors

Mental health counseling is an invaluable resource that is often not utilized but has been shown to provide benefits to well-being. Currently there is little to no menopause specific counseling education programs or classes. Treatments consist of treating the individual symptoms such as depression or anxiety; however, with careful research and evidence-based practices utilized, the mental health profession could create appropriate trainings for professional counselors to learn about the specific needs of PM Christian women and how to assist them to gain understanding of their condition and greater overall well-being. A holistic understanding of PM is needed for the provision of care.

Recommendations for Community Care Professionals

Community care could involve social services organizations that provide low-cost medical and mental healthcare to women, or other social support services. As PM affects all women at some point in their lives, women in all levels of socioeconomic statuses will experience symptoms of PM on some level. Women who have limited funds and resources do not need the added stress; therefore, support services could provide menopause education to women before the onset of symptoms to inform them of PM and menopause, explain possible symptoms they may experience, the biology of PM and menopause and what is happening in their body and why, and provide recommendations on attending support groups to share their experiences and gain further knowledge on PM.

Recommendations for Medical Professionals

Medical residency programs need to take the time, money, and effort into creating and developing appropriate research to educate residents on menopause. As mentioned, the life expectancy of the average female is 84 years (Carcelén-Fraile et al., 2020; Hunt, 2016; Sharma & Mahajan, 2015), meaning women can spend at least a third of their lives in postmenopause (28 years). Many medical school programs place a significant emphasis on obstetrics rather than menopause education. While obstetrics is highly important, many women are spending a longer period of their lives in menopause and may not get the care they need to navigate this part of their lives in a positive fashion as medical schools may not provide adequate enough education on menopause.

Recommendations for Counselor Educators

Counselor education programs can place a greater emphasis on menopause education through courses in human growth and development, social and cultural identity, career

development, group counseling, assessment courses, and research and program development. PM and menopausal women are in all facets of society and are of various cultural identities. PM and menopause are part of lifespan development. Many PM women are in the workplace and are doing what they can to navigate their symptoms and the work environment. Diversity, inclusion, and cultural sensitivity are needed in creating appropriate counselor education for PM women.

Areas for Future Study

There are many directions future study can go to provide improved care for PM Christian women based on the findings of this study. These recommendations will serve to fill gaps in the literature concerning PM Christian women, their physical and psychological needs, how to provide support, increasing menopause education in CMHC and medical school programs, encouraging conversation and open up communication, and ending the stigma associated with PM and menopause. The following areas have been identified as potential areas for future study concerning PM and menopause.

Ethnic Studies

Currently, there is a wealth of information published concerning the physical and psychological symptoms of PM; however, there is little available concerning the lived experiences of PM of any ethnicity. Quantitative studies exist detailing the significance of PM as a global health issue, which are important; however, qualitative studies are more difficult to obtain. Culturally and ethically competent ethnic studies into the global impact of PM can provide improved care for women of various cultures and ethnicities.

Socioeconomic Status

Healthcare for those in lower socioeconomic status is more difficult to come by; moreover, healthcare and education on PM and menopause is more than likely non-existent.

Healthcare, whether physical or mental, is a basic human need. The implementation of menopause education for those in lower socioeconomic status may prove to be beneficial for the people served.

Navigating the Internet: Information Reliability

As mentioned, navigating the internet to obtain reliable and dependable information is tricky. There are reliable books and websites that provide accurate information on PM and menopause (Appendix H). Future research into providing accurate, ethical, and evidence-based information and solutions may prove beneficial for PM women to make informed decisions about their medical and mental healthcare.

Age of Onset of PM: When PM Begins Earlier Than Expected

As expressed by younger participants of this study, they were surprised and scared at the prospect of entering PM, forcing them to reconsider their futures. Age of onset of PM is not predictable; therefore, informing younger women about PM may be helpful to lessen worries and fears about this phase in life. Support groups may prove to be beneficial for younger women entering PM to enable them to discuss their concerns and learn that they are not the only ones effected by PM.

Support Systems

Support systems are important for overall human functioning, as humans are social beings. Social support can take on many different forms such as friends, family, mentors, and support groups not facilitated by a professional (e.g., grief share, divorce care, celebrate recovery, often found in church environments). But adversity in life withdraws one from life, friendships, and means for support. Often, when faced with difficulties, a person withdraws and pushes people away, as mentioned by several study participants following entrance into PM.

Support systems can be of great benefit to PM Christian women. Further study into the benefits of social support during PM may yield positive outcomes for PM Christian women. Also, research into how R/S involvement or support through the church for PM Christian women is needed.

Women Who Have Had Surgical Interventions

Few studies involve women who have had surgical interventions and how they experience PM. Many studies, including this study, list surgical interventions such as a hysterectomy as exclusion criteria. Women who have had a hysterectomy or other surgical interventions to end menstruation experience PM; however, research is needed on their experience of PM and how their experience of PM is the same or different from women who have natural PM.

Medical School Curriculum

As mentioned, many medical school residency programs provide little menopause education to residents; however, inclusion of menopause education is important in women's health. To provide better care and enable PM and menopausal women to make informed decisions about their care, medical professionals need to be menopause informed. Future research into best practices into implementation of menopause education in medical school programs should lead to better health outcomes for women.

Summary

The preceding chapter presented a summary of the study findings discussed in Chapter 4, offered explanations of how each RQ was addressed by the themes and subthemes; provided a discussion on how the study findings connected and expanded the current literature and theoretical frameworks; highlighted theoretical, empirical, and practical implications, described

demarcations and limitations of this study and rationale for both; proposed recommendations for the various support systems for PM Christian women; and suggested areas for future study related to PM and menopausal women. In the summary of findings, RQs were discussed and addressed through the themes. RQ 1 was addressed by Primary Theme 1 in Subtheme 1.1 (bio-psycho-social-spiritual changes), and partially addressed in Subtheme 1.2 (self-identity) and Subtheme 1.3 (self-isolation), Primary Theme 2 in Subtheme 2.1 (know more about PM before the experience of PM) and Subtheme 2.2 (communication, education and awareness of PM), and Primary Theme 3 (positive coping and protective factors) specifically related to the biological and physical PM symptoms reported by participants. RQ 2 was also primarily answered by Primary Themes 1 and 3 and partially answered by the other themes and subthemes. RQ 3 was answered by Primary Theme 1, in Subtheme 1.1 (bio-psycho-social-spiritual changes) and in Primary Theme 2 with Subtheme 2.3 (destigmatizing PM) and partially addressed in Subtheme 1.3 (self-isolation). Finally, RQ 4 was addressed by Primary Theme 1, in Subtheme 1.1 (bio-psycho-social-spiritual changes) and Subtheme 1.2 (self-identity), and Primary Theme 3 (coping skills and protective factors).

Connections to the current literature focused on a discussion of the bio-psycho-social-spiritual aspects of PM, challenges women face during PM, coping mechanisms utilized and protective factors, and stigma experienced by PM women. Expansion of the current literature included a discussion on integration of the physical, biological, psychological, emotional, mental, cognitive, social, relational, interpersonal, and R/S factors that impact PM Christian women and women who fit outside of current documented literature (i.e., age of onset of PM younger than typically reported in the literature). Association and extension to the theoretical framework were also discussed in this section.

Implications of this study were identified and discussed related to their influence in future service provision. In this study the bio-psycho-social-spiritual model of functioning is incorporated with feminist theory to provide a model that depicts PM Christian women's general physical, emotional, relational, and R/S functioning, recognize areas for change, offer solutions to gain support and education needed to make informed decisions, increase awareness, confront and end practices that stigmatize, and provide empowerment to PM and menopausal Christian women (Arinder, 2020; Brabeck & Brown, 1997; Disch & Hawkesworth, 2016; Engel, 1997; Koenig, 2012; McCann & Kim, 2017; Porter, 2020; Saad et al., 2017). Understanding the effect of coping skills and protective factors on overall functioning and well-being will allow for greater understanding as well as develop suitable treatment and support protocols. Empirical implications were identified and related to provision of services for PM Christian women. Practical implications identified, include propositions for the counseling profession (i.e., individual, marital and family, and group counseling), medical profession, family resources and community care, R/S care and support and lay counseling, counselor education and supervision and CMHC programs of study, and CEUs. Specifically addressed in individual counseling were changes in self-identity, shifting roles, gains and losses, and counselors who are on the outside of the PM mold. Included in implications for counselor education and CMHC programs of study were the applicability of CACREP standards in the creation and development of PM and menopause counseling education curriculum and how that relates to counseling, supervision, teaching, research and scholarship, and leadership and advocacy. Lastly, the creation of CEUs specific to menopause counseling education was discussed.

Next, various recommendations were made with the hope that PM and menopause specific services can be established or improved to increase well-being for these women. Also

included are recommendations for counselor educators to develop PM and menopause specific counseling education for mental health counselors. Likewise, the expectation is that these recommendations can also benefit those who support PM Christian women. This section included recommendations for PM Christian Women, their personal support systems, mental health counselors, community care professionals, medical professionals, and counselor educators.

Finally, areas for future study were acknowledged and discussed to promote future research dedicated to PM and menopausal women's health moving into the future. These suggestions for further study allow for treatment protocols that would be culturally sensitive and culturally competent, provide for inclusion, equity, and dignified service provision. Areas for future study include ethnic studies, a focus on women of lower SES, acquiring reliable information online, age of onset of PM (e.g., women who began PM earlier than expected), support systems, women who have had surgical interventions, and medical school curriculum. There are several directions future research can take to provide more inclusive and improved care of the needs of PM Christian women. Through increased communication, increased knowledge, incorporation of professional and social support, medical and mental health specific menopause education, and greater understanding of the needs of PM and menopausal Christian women, the barriers to effective treatment and stigma can begin to be addressed.

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Appendix A Institutional Review Board Approval Letter

LIBERTY UNIVERSITY.
INSTITUTIONAL REVIEW BOARD

January 19, 2024

Sheri Cobarruvias
Deborah Braboy

Re: IRB Exemption - IRB-FY23-24-1085 The Lived Experiences of Perimenopausal Women: A Qualitative Phenomenological Study

Dear Sheri Cobarruvias, Deborah Braboy,

The Liberty University Institutional Review Board (IRB) has reviewed your application in accordance with the Office for Human Research Protections (OHRP) and Food and Drug Administration (FDA) regulations and finds your study to be exempt from further IRB review. This means you may begin your research with the data safeguarding methods mentioned in your approved application, and no further IRB oversight is required.

Your study falls under the following exemption category, which identifies specific situations in which human participants research is exempt from the policy set forth in 45 CFR 46:104(d):

Category 2.(ii). Research that only includes interactions involving educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures, or observation of public behavior (including visual or auditory recording) if at least one of the following criteria is met:
Any disclosure of the human subjects' responses outside the research would not reasonably place the subjects at risk of criminal or civil liability or be damaging to the subjects' financial standing, employability, educational advancement, or reputation; or

For a PDF of your exemption letter, click on your study number in the My Studies card on your Cayuse dashboard. Next, click the Submissions bar beside the Study Details bar on the Study details page. Finally, click Initial under Submission Type and choose the Letters tab toward the bottom of the Submission Details page. Your information sheet and final versions of your study documents can also be found on the same page under the Attachments tab.

Please note that this exemption only applies to your current research application, and any modifications to your protocol must be reported to the Liberty University IRB for verification of continued exemption status. You may report these changes by completing a modification submission through your Cayuse IRB account.

If you have any questions about this exemption or need assistance in determining whether possible modifications to your protocol would change your exemption status, please email us at irb@liberty.edu.

Sincerely,
G. Michele Baker, PhD, CIP
Administrative Chair
Research Ethics Office

Appendix B: Recruitment Letter

Dear Potential Participant,

As a doctoral candidate in the School of Behavioral Sciences, Counselor Education and Supervision Program at Liberty University, I am conducting research as part of the requirements for a doctoral degree. The purpose of my research is to explore the everyday lived experiences of perimenopausal Christian women from a physical, emotional, relational, and spiritual perspective. This research intends to enable the researcher and others who work with or support Christian women in perimenopause to understand the unique experiences perimenopausal Christian women face, provide a more holistic understanding of their lived experiences, and bring awareness to a global health issue. I am writing to invite you to join my study. This study has been approved by the Liberty University Institutional Review Board (IRB-FY23-24-1085).

Participants must be between 35 and 60 years of age, have a medical diagnosis or the presence of perimenopausal symptoms by non-surgical means as outlined in the screener questionnaire, be of the Christian faith, and be assigned female at birth. Participants will be asked to participate in a virtual, audio/video recorded interview via Zoom for Healthcare (HIPAA Compliant platform) that will take no more than 2 hours. Following the virtual interview (within one week of the interview), participants will be asked to review the interview transcript for accuracy and confirm agreement with the themes identified. Names and other identifying information will be requested as part of this study, but participant identities will not be disclosed.

To participate, please [click here] or contact me at [redacted] to schedule a short screening interview to determine eligibility. If you meet the research criteria, I will reach out to you via email to schedule an interview.

A consent document will be emailed to you if you meet the study criteria one week before the interview. The consent document contains additional information about my research. If you choose to participate, you must sign the consent document and return it to me by email before the interview.

Participants will receive a $25 gift card (e.g., Amazon, H-E-B, Walmart, Starbucks, etc.) at the conclusion of the study procedures.

Sincerely,

Sheri Collinsworth Cobarruvias
Doctoral Candidate, Counselor Education and Supervision, Liberty University
[redacted]

Appendix C: Recruitment Flyer

Research Participants Needed

The Lived Experiences of Perimenopausal Christian Women: A Qualitative Phenomenological Study

- Are you between 35 and 60 years of age?
- Do you have a medical diagnosis or the presence of perimenopausal symptoms by non-surgical means?
- Do you identify as a Christian?
- Were you assigned female at birth?

If you answered **yes** to each of the questions listed above, you may be eligible to participate in a research study. This study has been approved by the Liberty University of Institutional Review Board (IRB-FY23-24-1085)

The purpose of this research study is to explore the everyday lived experiences of perimenopausal Christian women from a physical, emotional, relational, and spiritual perspective. This research intends to enable the researcher and others who work with or support Christian women in perimenopause to understand the unique experiences perimenopausal Christian women face, provide a more holistic understanding of their lived experiences, and bring awareness to a global health issue.

Participants will be asked to participate in a virtual, audio/video recorded interview via Zoom for Healthcare (HIPAA Compliant platform) that will take no more than 2 hours. Following the virtual interview (within one week of the interview), participants will be asked to review the interview transcript for accuracy and confirm agreement with the themes identified.

Benefits include, by taking part in the study, participants will provide much-needed information to bring awareness to the needs of perimenopausal Christian women, assist those who work with or support perimenopausal Christian women, and contribute to the breaking down of barriers and destigmatizing discussion of perimenopause. Additionally, the information provided from this study will add to and update current literature on this topic to help mental health and medical professionals in working with perimenopausal Christian women.
At the conclusion of the interview, participants will receive a $25 gift card of their choice (e.g., Amazon, H-E-B, Walmart, Starbucks, etc.).

If you would like to participate, please scan the QR Code to the right to complete a screening survey.

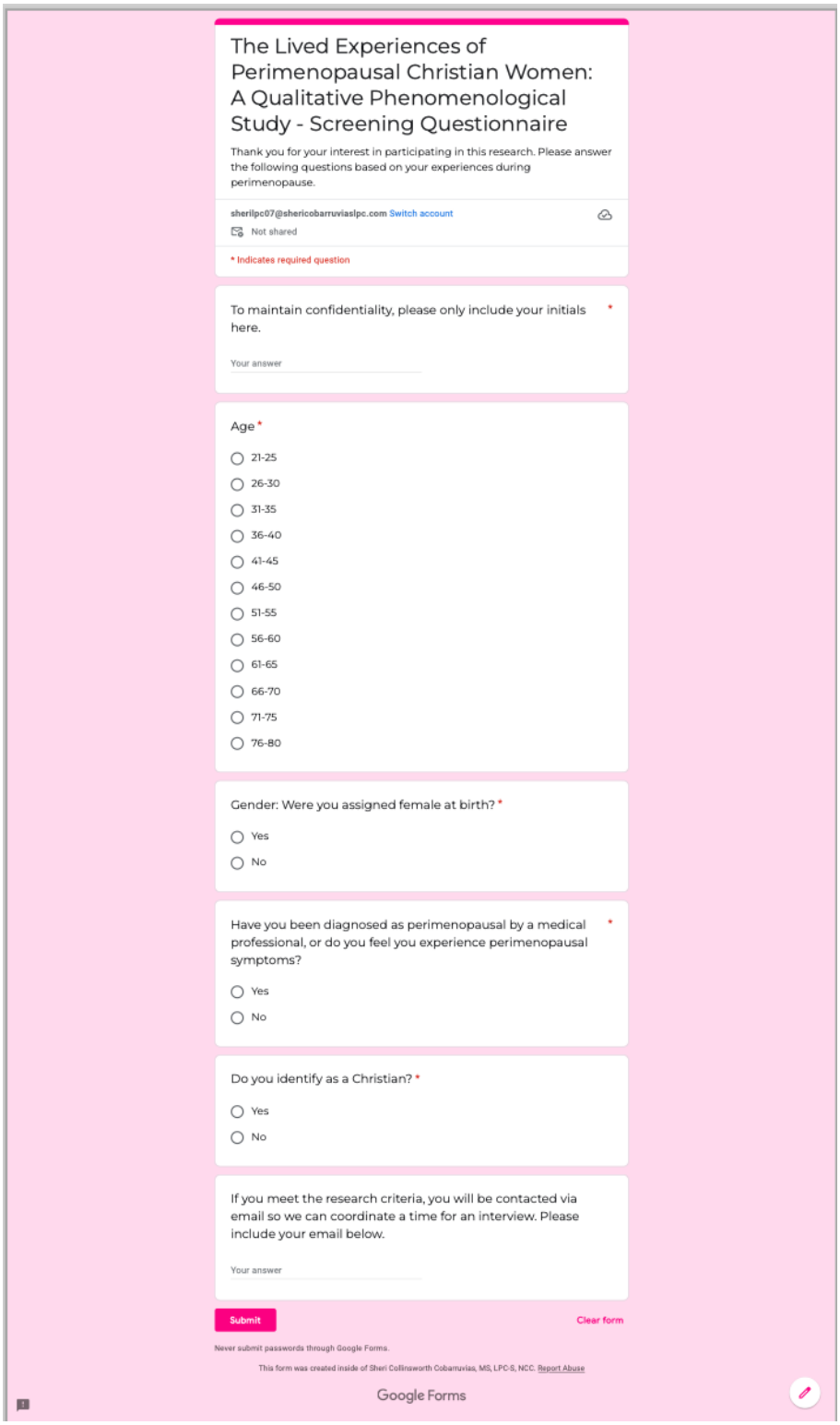
A consent document will be given to you one week before the interview.

Sheri Collinsworth Cobarruvias, a doctoral candidate in the Counselor Education and Supervision Program School of Behavioral Sciences at Liberty University, is conducting this study.

Please contact Sheri Collinsworth Cobarruvias at [redacted] for more information.

Liberty University IRB – 1971 University Blvd., Green Hall 2845, Lynchburg, VA 24515

Appendix D: Screening Questionnaire



The Lived Experiences of Perimenopausal Christian Women: A Qualitative Phenomenological Study - Screening Questionnaire

Thank you for your interest in participating in this research. Please answer the following questions based on your experiences during perimenopause.

sherilpc07@shericobarruviaslpc.com Switch account

Not shared

* Indicates required question

To maintain confidentiality, please only include your initials here. *

Your answer

Age *

- 21-25
- 26-30
- 31-35
- 36-40
- 41-45
- 46-50
- 51-55
- 56-60
- 61-65
- 66-70
- 71-75
- 76-80

Gender: Were you assigned female at birth? *

- Yes
- No

Have you been diagnosed as perimenopausal by a medical professional, or do you feel you experience perimenopausal symptoms? *

- Yes
- No

Do you identify as a Christian? *

- Yes
- No

If you meet the research criteria, you will be contacted via email so we can coordinate a time for an interview. Please include your email below.

Your answer

Submit Clear form

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This form was created inside of Sheri Collinsworth Cobarruvias, MS, LPC-S, NCC. Report Abuse

Google Forms

Appendix E: Data Collection Questionnaire

The Lived Experiences of Perimenopausal Christian Women: A Qualitative Phenomenological Study – Data Collection Questionnaire
(*TO BE COMPLETED BY INVESTIGATOR*)

Thank you for your interest in participating in this research. Please answer the following questions based on your experiences during perimenopause.

Participant initials: _____

Age: _____(*from screening questionnaire*)

Gender: Female? Yes ☐ No ☐ (*from screening questionnaire*)

Perimenopausal Diagnosis/Symptoms?: Yes ☐ No ☐ (*from screening questionnaire*)
Symptoms participant identified that have been experienced in the last three years from the list below:

Adverse Life Events ☐
Anxiety ☐
Cognitive Deficits ☐
Confusion ☐
Depression ☐
Emotional Instability ☐
Employment Issues ☐
Financial Issues ☐
Forgetfulness ☐
Headaches ☐
Hostility ☐
Hot Flushes ☐
Insomnia ☐
Irregular Menstrual Cycle ☐
Irregular Mood ☐
Metabolic Irregularities ☐
Night Sweats ☐
Random Aches & Pains ☐
Relationship Difficulties ☐
Sexual Dysfunction ☐
Weight Gain ☐

Mental Health Diagnosis (e.g., depression, anxiety, bipolar disorder)? Yes ☐ No ☐
Diagnosis: _____

Highest level of education?: _____

Christian?: Yes ☐ No ☐ (*from screening questionnaire*)

Appendix F: Information Sheet

Information Sheet

Title of the Project: The Lived Experiences of Perimenopausal Christian Women: A Qualitative Phenomenological Study
Principal Investigator: Sheri Collinsworth Cobarruvias, Doctoral Candidate, School of Behavioral Sciences, Liberty University

Invitation to be Part of a Research Study

You are invited to participate in a research study. To participate, you must be between 35 and 60 years of age, have a medical diagnosis or presence of perimenopausal symptoms by non-surgical means as outlined in the screener questionnaire, be of the Christian faith, and be assigned female at birth. Taking part in this research project is voluntary.

Please read this entire form and ask questions before deciding whether to participate in this research.

What is the study about and why is it being done?

The purpose of the study is to explore the lived experiences of perimenopausal Christian women from a biological, physical, mental, emotional, psychological, social, relational, religious, and spiritual perspective. The intent of this type of approach will enable the researcher and others who work with or support Christian women in perimenopause to understand the unique experiences perimenopausal Christian women face, provide a more holistic understanding of their lived experiences, and bring awareness to a global health issue.

What will happen if you take part in this study?

If you agree to be in this study, I will ask you to do the following:

1. Participate in a virtual, audio/video recorded interview via Zoom for Healthcare (HIPAA Compliant platform) that will take no more than 2 hours.
2. Following the virtual interview (within one week of the interview), participants will be asked to review the interview transcript for accuracy and confirm agreement with the themes identified.

How could you or others benefit from this study?

Participants should not expect to receive a direct benefit from taking part in this study; however, by taking part in the study, participants will be providing much-needed information to bring awareness to the needs of perimenopausal Christian women, assist those who work with or support perimenopausal Christian women, and contribute to the breaking down of barriers and destigmatizing discussion of perimenopause. Additionally, the information provided from this study will add to and update current literature on this topic to help mental health and medical professionals in working with perimenopausal Christian women.

What risks might you experience from being in this study?

The expected risks from participating in this study are minimal, which means they are equal to the risks you would encounter in everyday life. The risks involved in this study may include (but are not limited to) the possibility of psychological stress from being asked to recall potentially stressful situations. To reduce risk, I will monitor participants during interviews, discontinue them if needed, and provide referral information for counseling services.

I am a mandatory reporter. During this study, if I receive information about child abuse, child neglect, elder abuse, or intent to harm self or others, I will be required to report it to the appropriate authorities.

How will personal information be protected?

The records of this study will be kept private. Published reports will not include any information that will make it possible to identify a subject. Research records will be stored securely, and only the researcher will have access to the records.

- Participant responses will be kept confidential by replacing names with pseudonyms.
- Interviews will be conducted in a location where others will not easily overhear the conversation. Interviews will take place over Zoom for Healthcare (HIPAA Compliant platform).
- Data will be stored on a password-locked computer. After seven years, all electronic records will be deleted.
- Recordings will be stored on a password-locked computer for seven years and then deleted. The researcher will only have access to these recordings.

How will you be compensated for being part of the study?

Participants will be compensated for participating in this study; after the interview, participants will receive a $25 gift card of their choice (e.g., Amazon, H-E-B, Walmart, Starbucks, etc.). Email and/or mailing addresses will be requested for compensation purposes; however, they will be separated from your responses to the personal interview.

Is study participation voluntary?

Participation in this study is voluntary. Your participation will not affect your current or future relations with Liberty University or the researcher, Sheri Collinsworth Cobarruvias. If you decide to participate, you are free not to answer any question or withdraw at any time without affecting those relationships.

What should you do if you decide to withdraw from the study?

If you choose to withdraw from the study, please contact the researcher at the email address/phone number included in the next paragraph. Should you decide to withdraw, data collected from you will be destroyed immediately and will not be included in this study.

Whom do you contact if you have questions or concerns about the study?

The researcher conducting this study is Sheri Collinsworth Cobarruvias. You may ask any questions you have now. If you have questions later, **you are encouraged** to contact her at [redacted] You may also contact the researcher's faculty sponsor, Deborah Ann Braboy, Ph.D., at [redacted]

Whom do you contact if you have questions about your rights as a research participant?

If you have any questions or concerns regarding this study and want to talk to someone other than the researcher, **you are encouraged** to contact the IRB. Our physical address is Institutional Review Board, 1971 University Blvd., Green Hall Ste. 2845, Lynchburg, VA, 24515; our phone number is 434-592-5530, and our email address is irb@liberty.edu.

Disclaimer: The Institutional Review Board (IRB) is tasked with ensuring that human subjects research will be conducted in an ethical manner as defined and required by federal regulations. The topics covered and viewpoints expressed or alluded to by student and faculty researchers are those of the researchers and do not necessarily reflect the official policies or positions of Liberty University.

Appendix G: Interview Questions

The following questions are asked of participants:

Part I: Introduction, Self-Identification, and Understanding

1. Please introduce yourself as you would if we met for the first time.
2. What is your first thought when you hear "perimenopause?"
3. How has perimenopause affected your life routine?
4. In what way has your experience with perimenopause affected/impacted/influenced your assumptions about yourself?
5. How has your experience with perimenopause affected/impacted/influenced your assumptions about your relationship experience with the world around you?

Part II: Bio-Psycho-Social-Spiritual of Perimenopause

Biological:

For the following questions, you will be asked to focus only on your biological or physical experiences concerning your experience in perimenopause.

6. Please reflect on the time before being informed that you were in perimenopause; what physical symptoms did you experience, and how long did you experience these symptoms before speaking with a physician(s)?
7. Once speaking with the physician(s), how long did it take for you to be informed that you were in perimenopause (i.e., what was involved in arriving at the doctor(s) assessment and were multiple doctors consulted)?
8. How have your biological or physical perimenopausal symptoms changed since being told you are in perimenopause?
9. How has perimenopause affected how you take care of your physical health?

Psychological:

For the following questions, you will be asked to focus only on your psychological, mental or emotional experiences concerning your experience in perimenopause.

10. Please reflect on the time before being informed that you were in perimenopause; what psychological, mental, or emotional symptoms did you experience, and how long did you experience these symptoms before speaking with a physician(s)?
11. Once speaking with the physician(s), what recommendations were made to address your psychological, mental, or emotional symptoms?
12. How have your psychological, mental, or emotional perimenopausal symptoms changed since being told you are in perimenopause?
13. How has perimenopause affected how you take care of your psychological, mental, or emotional health?

Social:

For the following questions, you will be asked to focus only on your social understandings concerning your experience in perimenopause.

14. Please describe your roles or hats in your world (e.g., wife, mother, employee (position/company), daughter, friend, etc.).
15. How would you describe your social support?
16. Please reflect on the time before being informed that you were in perimenopause; were there any social issues you experienced that you felt may have been related to perimenopause?
17. Once speaking with the physician(s), what recommendations were made to address these social issues, or what remedies did you try on your own?

18. How have the social issues you experienced changed since being told you are in perimenopause?
19. As a result of perimenopause, in what ways have the roles you play in your life changed?
20. As a result of perimenopause, how have any of the roles you play in your life been affected?
21. How has perimenopause affected how you take care of your social life?

Spiritual:

For the following questions, you will be asked to focus only on your R/S understanding. concerning your experience in perimenopause.

22. Please reflect on the time before being informed that you were in perimenopause; were there any R/S issues you experienced that you felt may have been related to perimenopause?
23. Once speaking with the physician(s), what recommendations were made to address these R/S issues, or what remedies did you try independently?
24. How have the R/S issues you experienced changed since being told you are in perimenopause?
25. How has perimenopause affected how you take care of your R/S life?

Part III: Treatment and Coping Strategies

*For the following questions, reflect on the types of treatment or coping skills you employed to alleviate or manage your symptoms **during** perimenopause.*

26. What coping strategies did you employ to manage your symptoms ***during*** perimenopause, and how were these strategies helpful?

27. Where do protective factors such as spirituality, self-care, and support fit into your coping strategies ***during*** perimenopause?

Part IV: Future Recommendations

28. What would you like to have known before entering perimenopause?
29. What changes could be made, based on your own experience, to better prepare women for what they will experience during perimenopause?

Conclusion: Thank you for your patience and willingness to participate in this interview and study. I greatly appreciate you sharing such personal and intimate information. I do have one additional question in closing our meeting today: Is there any other information that you can think of that would help me have a more complete understanding of your experiences during the perimenopause?

Appendix H: Resources

Media Type	Creator/Developer	Title	Location
Books	The Boston Women's Health Book Collective	*Our Bodies, Ourselves*	
	Tricia Brouk & Alexandra Stockwell, MD	*The Invitation: Vital Conversations About Menopause*	
	Heather Corinna	*What Fresh Hell is This?: Perimenopause, Menopause, Other Indignities, and You*	
	Dr. Jen Gunter	*The Menopause Manifesto: Own Your Health with Facts and Feminism*	
	Dr. Mary Claire Haver	*The New Menopause*	Available April 30, 2024
	Steven F Hotze, MD & Kelly Griffin	*Hormones, Health, & Happiness*	
Websites	Dr. Mary Claire Haver	*The 'Pause Life*	https://thepauselife.com
	Naomi Whittel	*5 Things Every Woman Should Know About Peri-Menopause and Menopause*	https://naomiw.com/blogs/body-soul/5-things-every-woman-should-know-about-peri-menopause-and-menopause?_pos=1&_sid=bcee96f11&_ss=r
	North American Menopause Society (NAMS)		https://www.menopause.org
	Our Bodies, Ourselves Today		https://www.ourbodiesourselves.org
	Tamsen Fadal	*Menopause*	https://www.tamsenfadal.com/categories/menopause
	Tamsen Fadal	*Menopause Masterclass*	https://www.tamsenfadal.com/categories/menopause-masterclass