PERSPECTIVE-TAKING, SELF-TALK, AND SOCIAL CONNECTION: A PHENOMENOLOGICAL STUDY OF HOW INDIVIDUAL PRACTICES REDUCE LONELINESS DURING THE MENOPAUSAL YEARS

by

Sarah Groff

Liberty University

A Dissertation Presented in Partial Fulfillment

of the Requirements for the Degree

Doctor of Philosophy

Liberty University

[Month, Year]

APPROVED BY:

_____

Donna Busarow, PhD, Committee Chair

_____

Name and degree, Committee Member

ABSTRACT

Menopause is a stage of the life cycle known for physical, mental, and emotional changes. Many women report feeling isolated and lonely during this time due to changes in hormones and physical appearance, lack of sleep, uncertainty about their role after raising children, and cultural pressures to remain thin and beautiful. Due to the lack of education and normalization of this life change, women often withdraw and become increasingly depressed or anxious, as a result. Loneliness is associated with higher levels of depression, anxiety, suicidality, premature death, and a variety of other physical ailments. However, previous research suggests that the practice of solitude, faith, perspective-taking, self-talk, and social connection are effective in reducing these symptoms. In this phenomenological study, women who were identified as being of menopausal age (40-60 years) were interviewed about their experience of loneliness and subsequent coping skills during this life stage. The goal of this study was to learn from the insight and practice of menopausal women in how they coped with loneliness and altered their perspective of being alone. Participants sought relief through the practice of solitude, faith, perspective-taking, self-talk, and social connection. Key factors that enabled women to access these skills had to do with the normalization and validation of their experience, which was needed from partners, peers, medical practitioners, and therapists. This information was then conveyed to medical, spiritual, and mental health practitioners to enhance their assessment and treatment of women presenting with loneliness and other symptoms related to menopause.

Keywords: loneliness, women, motherhood, menopause, isolation, solitude

Copyright Page

Dedication

To my mother, who has always believed in me and supported me along life's journey, no matter the circumstances. You gave me the gift of purpose, of knowing my life was made for a purpose. That is the greatest gift a parent could give a child and I am so grateful.

Acknowledgments

This project would never have been possible without the dedication, critique, and tireless support of my committee members, Dr. Busarow and Dr. Clark. I feel so fortunate to have worked with you both and truly appreciate every editing remark and suggestion for change, as each comment only made my study and overall dissertation stronger. Thank you so much for your kindness and rigor. I appreciate you both.

TABLE OF CONTENTS

List of Figures

CHAPTER 1: INTRODUCTION TO THE STUDY

Introduction

The detrimental side effects of loneliness, including physical and psychological ailments, have been well documented (Achdut & Refaeli, 2021; Arbuckle, 2022; Arimoto & Tadaka, 2021; Brown & Munson, 2020; & Curran et al., 2019). McKenna-Plumley et al. (2021) observed that the COVID-19 pandemic of 2020 taught us that physical distance contributes to individual feelings of social isolation and disconnect, despite the advances in technology that allow for virtual communication. In addition, they explained that loneliness is a subjective, and therefore often hidden, experience that is based upon the disconnect between one's expected and actual social connections. Within this context, loneliness may occur and can contribute to a variety of internalizing and externalizing symptoms, including hopelessness, isolation, suicidal ideation, loss of purpose, relational problems, substance abuse, uncontrolled anger, conflict with friends and family, and existential crisis (Adamczyk et al., 2022; Austin et al., 2018; Davis et al., 2019; Maes et al., 2019; Mund et al., 2020; Trevino et al., 2019; Williams, 2022).

Although loneliness is a universal experience and occurs across the lifespan, certain epochs seem to be especially vulnerable to loneliness and its negative side effects (Arimoto & Tadaka, 2021; Augustijn, 2021). This holds true despite culture, as well. One of these specific phases in the lifespan is menopause, which often coincides with physical changes, launching of children from the home, and reevaluation of a woman's purpose and meaning (East et al., 2017; Gadban & Goldner, 2020; Guthrie-Gower & Wilson-Menzfeld, 2022; Lee et al., 2019; Ozcan et al., 2022; Pineros-Leano et al., 2021).

Background

One of the factors that complicates loneliness among women, whether they are experiencing post-partum depression, discontent with the sadness of being an empty nester, or gaining weight due to menopause, is the stigma and pressure associated with disclosing this experience and seeking validation and support. For example, Lee et al. (2019) explained that, particularly in Western culture, there is pressure to appear happy, well adjusted, and radiant following the birth of a baby. There is also the belief that women should be relieved their children are grown and successfully out of the home (Yazdkhasti et al., 2019). When women unexpectedly feel sad or lonely, therefore, they often choose not to disclose their feelings in order to save face and avoid judgment.

Not only are pregnancy and delivery reported to be times of profound loneliness for women, but menopause is often associated with these feelings, as well (Ozcan et al., 2022). With an average age of onset at 51, Ozcan et al. found the menopausal stage to be fraught with loneliness for many women. According to their study, most women (99%) did not view menopause as a normal life process and expressed fears of losing their beauty, femininity, role, and significance once they were no longer able to have children or had raised their children. In tandem with various physical and sexual changes, Ozcan et al., Kaur & Kaur (2021), and Yazdkhasti et al. (2019) also found that menopausal women felt increasingly lonely and suffered from a displaced sense of self and purpose.

Given the risk of depression, anxiety, and disillusionment associated with loneliness, symptoms which can also foster shame and make it difficult for women to seek help, it is important this period of the lifespan not be overlooked. In keeping with Jovicic and McPherson's (2019) recommendation, it is essential to develop an individual and personalized understanding of loneliness in order to treat it appropriately. While there exists a significant amount of research

that focuses on quantitative measures of loneliness, particularly among the elderly, there is still so much to learn about how to prevent or overcome loneliness. In addition, we lack understanding about how women can learn to cope positively with the myriad changes that occur during the menopausal years. Although the physical aspects of menopause are often talked about in medical journals, there is a lack of conversation and knowledge among mental health practitioners about the internal experience of isolation and loneliness associated with this stage of life, in part because women do not talk about it openly (Kaur & Kaur, 2021; Kent-Marvick et al., 2022; Lee et al., 2019; McComb et al., 2020; Ozcan et al., 2022; Yazdkhasti et al., 2019). In addition, the current literature seems more focused on the negative side effects of loneliness versus learning which skills and coping mechanisms already exist to successfully abate loneliness in its most detrimental forms.

In addition to the psychological research conducted on loneliness, the Bible also offers a human and balanced perspective on this topic. In its portrayal of individual struggles and victories, the Bible does not shy away from the experience of loneliness and solitude, providing pictures of the isolation one can feel from others and God, while also encouraging individuals to seek out moments of solitude to pray, reflect, and to be refreshed.

The Psalms written by David are one of the most recognizable acknowledgements of loneliness. For example, David often wrote about feeling abandoned by God, asked if God had forgotten him, and beseeched God to remember him. One instance of this can be found in Psalm 10:1 when David asked, “God, are you avoiding me? Where are you when I need you?” (*The Message,* 2002/2010). On another occasion, he wrote “Why did you dump me miles from nowhere? Doubled up with pain, I call to God all the day long. No answer. Nothing. I keep at it all night, tossing and turning” (*The Message,* 2002/2010, Psalm 22:1-2). While these passages

coincided with David's ongoing retreat from King Saul and his feelings of loneliness related to God's lack of tangible intervention, other passages addressed the loneliness he felt as a result of his family's rejection and the prolonged period he was running from Saul and hiding in caves. Each of these accounts described the emotional and psychological agony of being alone, feeling forgotten or rejected, isolated from society, and frustrated with the lack of change. Although David had great faith, he was also a man who experienced the very real pain of loneliness. In fact, on more than one occasion, David expressed depressed and suicidal thoughts: "God, God, save me! I'm in over my head, Quicksand under me, swamp water over me, I'm going down for the third time. I'm hoarse from calling for help, Bleary-eyed from searching the sky for God" (*The Message,* 2002/2010, Psalm 69:1-3). Again, this passage coincided with David's exile from home and the people he loved while fleeing King Saul, reflecting the gravity of the isolation and loneliness he felt.

While David's Psalms depicted a bleak picture of loneliness, separate accounts in the Bible tell of Daniel's daily habit of withdrawing to his room in order to pray (*The Message,* 2002/2010, Daniel 6:10), of Mary's silent cherishing of all the things she witnessed surrounding Jesus' birth (*The Message,* 2002/2010, Luke 2:19), and Joseph's demand to be left alone with his conflicting emotions of sorrow and relief when reunited with his brothers in Egypt (*The Message,* 2002/2010, Genesis 45:1-2). Each of these stories demonstrated an individual's pursuit of solitude to either grieve, reflect, or seek God's presence and direction. Even Jesus sought solitude to pray (*The Message,* 2002/2010, Matthew 14:23; 26:39) and grieve the death of his cousin John (*The Message,* 2002/2010, Matthew 14:13).

One of the most straightforward admonishments for solitude in the Bible is found in Lamentations 3:28-30: "When life is heavy and hard to take, go off by yourself. Enter the

silence. Bow in prayer. Don't ask questions: Wait for hope to appear" (*The Message*, 2002/2010). This passage acknowledges the painful and overwhelming challenges of life, while also offering a solution, which is solitude.

This study explored the skills of solitude, practicing faith, perspective-taking, self-talk, and social connection to observe whether they helped to reduce the detrimental effects of loneliness among women during the menopausal years. This included examining the coping strategies women have adapted across social, cultural, and economic contexts that have allowed them to navigate being alone and to thrive despite loneliness. According to Nelson et al. (2022), it is important to recognize that loneliness may occur within specific contexts of gender, culture, and race, the nuance of which quantitative studies often overlook. Conducting a qualitative study, therefore, added to the existing knowledge about loneliness and its related coping mechanisms by going directly to the individuals who have experienced it and learning from their in-depth description of the thought processes, emotions, and behaviors related to loneliness and their subsequent coping skills.

Problem Statement

Loneliness is a universal phenomenon that encompasses the entire lifespan and is experienced across all cultures, genders, and age groups. It occurs when there is a disconnect between an individual's expected social interaction or experience of intimacy and their actual experience (Mund et al., 2020). When this disconnect in qualitative or quantitative connection is internalized as negative or deficient, then loneliness occurs (Arimoto & Tadaka, 2021; Franssen et al., 2020). Salo et al. (2020) and Hemberg et al. (2021) observed there are two types of loneliness: social and emotional. The former is a perception of being disconnected from friends or social experiences, feeling left out, or sadness about not connecting with one's peer group,

cohort, or activity-related group. This type can cause an individual to isolate even more out of fear of being rejected (Pearce et al., 2022). The latter, known as emotional loneliness, is an internalized feeling of sadness or loss due to a lack of connection with friends and family. This type can lead to withdrawal, low self-esteem, or self-loathing. According to Hemberg et al. and Salo et al., this does not necessarily signify the absence of relationships (quantity), but the lack of or desire for interpersonal intimacy (quality).

The menopausal years are known to bring both social and emotional loneliness for many women, which compounded with the vast physical and familial changes at this time of life, can lead to high levels of depression and anxiety (Kaur & Kaur, 2021; Maes et al., 2019; Ozcan et al., 2022). As such, Ozcan et al. (2022) advocated for a deeper understanding of the root cause of women's varying emotions and loneliness during the menopausal years so that prevention efforts and appropriate interventions can be utilized as deterrents against debilitating loneliness. The current gap in psychological and medical literature on this topic leaves women wanting for validation and support. Ozcan et al. noted this lack of validation and normalization prevents many women from disclosing their concerns and mental health struggles, which then perpetuates their tendency to withdraw, feel isolated or ashamed, and to develop anxiety and depression as a result.

The literature reviewed in this study demonstrates that the skills of practicing faith, perspective-taking, positive self-talk, and social connection are highly effective in reducing loneliness among a variety of populations (Arbuckle, 2022; Batcho, 2021; Bjørge et al., 2019; Fakoya et al., 2021; King, 2018; Nguyen et al., 2018; Oles et al., 2020; Pineros-Leano et al., 2021; Preece et al., 2021; & Thomas, 2023). Furthermore, Nguyen et al. (2018) found that people's mood and ability to emotionally regulate decreased when alone, noting this was more

likely when alone time was unwanted or prolonged. However, they also found that for those who understood the personal benefits of solitude, affective responses were more positive and being alone was not considered an experience to avoid. These studies indicate that people possess within themselves the ability to practice perspective-taking, self-talk, solitude, and social connection when taught (Abedi et al, 2020; Batcho, 2021; Gadban & Goldner, 2020; Nelson et al., 2022; Pineros-Leano et al., 2021; Ross et al., 2021; Tagomori et al., 2022; & Yazdkhasti et al., 2019). In addition, it is worth noting the influence of accurate information in normalizing feelings of loneliness, which is key to helping individuals feel less isolated in their experience and more likely to talk with others. With this in mind, the author of this study questioned whether menopausal women could benefit from these coping mechanisms if given the opportunity to learn them. In order to know what education and training are necessary for menopausal women, it is important to first understand the experience of loneliness among this population, as well as factors related to reducing loneliness.

Purpose of the Study

The purpose of this qualitative phenomenological study was to explore the lived experience of loneliness in menopausal women. Furthermore, factors related to reducing loneliness in this life stage were examined.

Research Questions

Research Questions

RQ1: How do menopausal women describe their experience with loneliness?

RQ2: How do menopausal women describe the factors related to reductions in loneliness during the menopausal years? For the present study, these factors were identified as the practice of solitude, faith, perspective-taking, self-talk, and social connection.

Assumptions and Limitations of the Study

Anticipated limitations with this study had to do with the format intended to collect data, which was through individual and group interviews. This type of data collection is inherently time consuming and requires extremely thorough note taking, correctly working recording devices or technology, and a very careful review of the information gathered in order to accurately represent the participants' lived experiences and categorize them into themes. Retention could have also been an issue during the time elapsed between individual and group interviews, although the author scheduled these interviews relatively close together and asked participants to agree to both interviews upon providing consent to reduce attrition. Having said that, participants were also informed that they could discontinue participation in the study at any time for any reason without fear of retribution.

Another potential challenge had to do with the author's own bias getting in the way in the form of judgments or preconceived ideas. This is why it was essential for the author to practice self-awareness and bracket herself from the information shared, as much as possible. It was also important for the author to suspend judgment or personal beliefs regarding loneliness, its clinical side effects, and best practices for resolving loneliness so that participants could shed light on the coping mechanisms that worked best for them. Limitations to this study had to do with the generalizability of participants to a larger menopausal population, especially across culture. Although menopause and loneliness are joint phenomena reported across culture and demographics (Kaur & Kaur, 2021; Ozcan et al., 2022; & Yazdkhasti et al., 2019), those who choose to respond to the recruitment notice may have been more inclined to participate in research studies, had some vested interest, or may have only represented a certain segment of

women. Finally, it was possible that participants' recollection of events may have been distorted by time and loss of memory.

As for assumptions, the author assumed that participants would describe their experience of the menopausal years and loneliness accurately, which was facilitated by the open-ended interview style of this study. In this type of phenomenological qualitative study, participants are assumed to possess the knowledge to answer the author's questions and to be experts in their own experience.

Theoretical Foundations of the Study

According to the social evolutionary theory, loneliness is theorized to act as a protective mechanism against possible rejection and increases one's awareness of social connection (Pearce et al., 2022). Mund et al. (2020) expanded on this idea by explaining that over time, humans have come to rely upon social interaction as a form of support, thereby helping to ensure survival. Having access to multiple relationships that are also diverse in nature is known to decrease the likelihood of being isolated and therefore, reduces the risk of developing various negative psychological, physical, and neurological problems associated with social isolation.

In their work with existential-humanistic self-development theory (EHSDT), DeRobertis and Bland (2019) expand upon this idea of social development and how social connection inhibits isolation and subsequent loneliness. They describe the theory as one that views the development of a holistic self, occurring within the context of relationships. According to this theory, development consists of an ongoing process known as "negotiation of paradox," which takes place within this social context (DeRobertis & Bland, 2019, p. 5). It involves the never-ending development of the "person-in-process" who actively and intentionally grows in their self-awareness within the system, or environment, in which they exist (DeRobertis & Bland,

2019, p. 6). DeRobertis and Bland further explain that as part of their development, humans strive to reduce stress related to their environment or certain life challenges (paradoxes) through self-regulation, including emotional regulation. They also practice self-enriching activities, such as engaging with others, because this act reduces the tension or stress mentioned above and releases pleasure. In other words, EHSDT views humans as consistently making efforts to reduce their isolation from others and to actively engage in connection with them out of an innate awareness that this is good for physical and emotional well-being. DeRobertis and Bland also note that because EHSDT pays attention to individuals' lived experience, it prioritizes phenomenological research, thus making it an appropriate fit for this present study.

Like DeRobertis and Bland (2019), Purswell (2019) explains that humanistic learning theory views development as a holistic process which involves the emotional, social, and mental aspects of every human being. Rather than focusing on the acquisition of knowledge, this theory states that one's unique way of interacting with the world shapes his/her application of abilities and knowledge. Integral to this theory, Purswell explains, are Rogers' tenets of empathic understanding, unconditional positive regard, and transparency. In Rogers' view, these elements are necessary for healing within the therapeutic setting, as well as for respect and growth within the academic one. Likewise, this present study was curious about how these elements of social connection, imbued with empathy, transparency (which leads to normalization), and self-knowledge, reversed the experience of loneliness during menopause and allowed women to feel connected and supported.

The Bible also offers insight and instruction for addressing loneliness by embracing solitude as an avenue for reflection, prayer, and perspective-taking (*The Message*, 2002/2010, Psalm 3:7; Lamentations 3:29-30). Additionally, the biblical scriptures emphasize the importance

of community and social connection with like-minded peers as a means of gaining support and staying the course (*The Message*, 2002/2010, Luke 1:39, 56; Acts 2:42-47; James 3:18). These constructs of loneliness, solitude, reflection, self-talk, perspective-taking, and social connection were explored throughout this study as they pertained to women's lived experience of loneliness during the menopausal years.

Definition of Terms

The following is a list of definitions of terms that were used in this study:

Emotional Loneliness - An internalized feeling of sadness or loss due to a lack of connection with friends and family. This type can lead to withdrawal, low self-esteem, or self-loathing. This does not necessarily signify the absence of relationships (quantity), but the lack of or desire for interpersonal intimacy (quality) (Hemberg et al., 2021; Salo et al., 2020).

Isolation - An absence of relationships, which is an objective experience observable by others (Thomas & Azmitia, 2019; Williams, 2022).

Loneliness – A subjective, internal emotional interpretation and response to being alone (Thomas & Azmitia, 2019). A phenomenon that occurs when there is a disconnect between an individual's expected social interaction or experience of intimacy and their actual experience (Mund et al., 2020). When this disconnect in qualitative or quantitative connection is internalized as negative or deficient, then loneliness occurs (Arimoto & Tadaka, 2021; Franssen et al., 2020).

Menopause – Signified by 12 months of amenorrhea, the absence of a menstrual cycle, with no other explanation. This represents the end of a woman's ability to reproduce (Minkin, 2019).

Social Loneliness - The perception of being disconnected from friends or social experiences and feeling left out. It also includes sadness about not connecting with one's peer group, cohort, or other activity-related group (Hemberg et al., 2021; Salo et al., 2020).

Solitude – May be intentional or unintentional. When solitude is not intentional it can lead to the painful experience of longing for interaction and belonging, especially when an individual feels he/she has been excluded from a particular social group (Teneva & Lemay, 2020). When it is intentional, however, Thomas (2023) and Thomas and Azmitia (2019) noted that solitude is distinguished from loneliness in that it is seen as a time to relax, pursue personal interests, and reflect.

Significance of the Study

This phenomenological qualitative study was significant in that it allowed practitioners to gain a broader understanding of participants' lived experience of loneliness and the subsequent coping mechanisms they have developed to alleviate the negative mental and emotional side effects of loneliness during the menopausal years. By gathering first-hand information via semi-structured interviews, this study highlighted participants' differing experiences, perspectives of loneliness, and ways in which they have learned to manage and cope throughout the menopausal years. These first-hand accounts also helped to identify what other factors, if any, contributed to the development or sustainment of loneliness during this period of the lifespan.

Given there is little research to date regarding the experience of loneliness for women during the menopausal years due to their shifting roles, purpose, and physicality, this study also had the potential to validate and normalize this experience for many women. Normalization is key to seeking help for many individuals and when practitioners are made aware of the potential for unique struggles during menopause, they can screen for depression, anxiety, and other mental health issues related to this stage of life. Additionally, they can teach skills of coping and resiliency that come directly from other women who have successfully navigated these challenges by employing said skills. The author of this study intended to make this information

available to mental health clinicians to enhance their understanding of loneliness, as well as their ability to properly identify the needs and treatment interventions for this population. Ultimately, the goal for this study was for menopausal women to feel validated in their experience and to gain understanding and skills that will enable them to regain hope and perspective, eliminate loneliness and its negative side effects, and finally, to embrace their life changes while continuing to move forward in healthy and adaptive ways.

Summary

Loneliness can be a very isolating experience for many and when it occurs during certain transitional times during the lifespan, it can be especially debilitating. Salo et al. (2020) found that loneliness can cause anxiety, depression, low self-esteem, and withdrawal. In addition, loneliness creates a very real sense of distress for many (Franssen et al., 2020), which can lead to suicidality in some cases, as well as a sense of despair or questioning of one's purpose (Achdut & Refaeli, 2021; Williams, 2022).

The menopausal years (typically between the ages of 40 and 60), are often reported to be years of isolation, a decreased sense of purpose or importance, lowered self-esteem due to physical and sexual changes, and sadness related to the launching of children or inability to physically have more children (Ozcan et al., 2022). However, some women across a variety of cultures and socioeconomic situations have decided to find happiness or pursue hobbies or other interests as a means of coping with these changes (Abedi et al., 2020; Gadban & Goldner, 2020; Guthrie-Gower & Wilson-Menzfeld, 2022; Kaur & Kaur, 2021; Pineros-Leano et al., 2021; Prinzing et al., 2023; Ross et al., 2021; & Yazdkhasti et al., 2019). The studies of Batcho (2021), Bjørge et al. (2019), Fakoya et al. (2021), Kang et al. (2021), King (2018), McKenna-Plumley et al. (2021), Nelson et al. (2021), Nguyen et al. (2018), Oles et al. (2020), Paredes et al. (2021),

Preece et al. (2021), and Thomas (2023) have also shown that practicing faith, positive self-talk, perspective taking, and engaging in solitude or social connection are known to reduce the negative side effects of loneliness. This study utilized the information gained in semi-structured interviews with women who have experienced loneliness in various stages of menopause to learn about the coping skills they employed to help them navigate this life stage in healthier and less lonely ways.

CHAPTER 2: LITERATURE REVIEW

Overview

While there exists a significant amount of research that focuses on quantitative measures of loneliness, particularly among the elderly, there is still so much to learn about how to prevent or overcome loneliness. In addition, there is very little research (quantitative or qualitative) about this topic as it pertains to women during the menopausal years. Although the physical aspects of menopause are often talked about in medical or social circles, there is a lack of conversation and knowledge about the internal experience of isolation and loneliness associated with this stage of life. In addition, the current literature seems more focused on the negative side effects of loneliness versus learning which skills and coping mechanisms already exist to successfully abate loneliness in its most detrimental forms.

The literature reviewed in this chapter addresses the negative mental and emotional side effects of prolonged or unwanted isolation, specifically how it contributes to feelings of loneliness, anxiety, depression, and low self-esteem. It also sheds light on the ways these symptoms are often exacerbated and uniquely experienced throughout the pre-, menopausal, and post-menopausal years of the life span. Finally, the literature demonstrates how certain skills, such as perspective taking, positive self-talk, practicing faith, and social connection, act as moderating factors on the negative effects of loneliness (Brinthaupt, 2019; Jenkins et al., 2022; Thomas & Azmitia, 2019).

Description of Search Strategy

The literature review for this study was conducted by using the electronic search engines PsycINFO, ProQuest, and Google Scholar. These search engines were chosen in order to review literature from a variety of disciplines, including psychology, sociology, medicine, and religion.

Search terms included the constructs of loneliness and mental illness, loneliness and depression or anxiety, solitude and mental health, loneliness and menopause, traits of practicing solitude, and so forth. Each search resulted in new terms that were also pursued, including perspective-taking and loneliness, reflection and solitude, and maternal loneliness. Both qualitative and quantitative studies were reviewed, as well as meta-analyses. Only studies published since 2019 were reviewed. Other delimitations included only scholarly and peer reviewed articles, full text articles, and articles written in or translated to English.

The biblical portion of this study was conducted through word study using Strong's concordance (1990), as well as the author's own knowledge of the biblical scriptures.

Review of Literature

There is a high correlation between loneliness and depression, cognitive impairment, low self-esteem, aggression, and apathy (Teneva & Lemay, 2020). In fact, according to Jenkins et al. (2022), individuals who struggle with certain mental health issues are more likely to experience loneliness, as their diagnosis may lead to further exclusion or isolation. In their meta-ethnography of 20 qualitative studies regarding the experience of loneliness among cancer patients, Raque-Bogdan (2019) found that loneliness is an internalized feeling, one that often remains unseen or misconstrued by others. This is especially true when patients fear judgment for their feelings of loss, grief, and loneliness. In the articles reviewed in this study, cancer survivors described feeling increasingly isolated due to the lack of relatability to their experience and subsequent emotions. To compound matters, they also struggled with the impersonal healthcare system that was not designed to recognize or address their varying emotions. Raque-Bogdan's analysis highlighted three important contributions to the creation of loneliness, which will also be recognized throughout the following examples from other literature. In addition, they

recommended these themes be kept in mind when designing interventions to help reduce loneliness. These themes included shame, isolation, and a treatment system and social structure ill-equipped to deal with the negative side effects of loneliness.

Components of Loneliness

There are various components to loneliness, including physical, mental, emotional, relational, and spiritual. Depression, anxiety, suicidality, hopelessness, isolation, and loss of purpose are known as internalizing symptoms, whereas romantic crisis, substance abuse, the act of suicide, behavioral problems, withdrawal, and noncompliance with medical treatment are considered externalizing symptoms (Adamczyk et al., 2022; Austin et al., 2018; Davis et al., 2019; Maes et al., 2019; Mund et al., 2020; Williams, 2022).

Physical Component

Mund et al. (2020) and Williams (2022) noted that loneliness can increase the risk of inflammation, high blood pressure, heart disease, stroke, and early death, particularly by suicide. In her review of the physical and mental health effects of loneliness, Williams, who is a mental health nurse and educator, referred to the United Kingdom and Wales' conclusion that loneliness was a greater contributor to premature death than obesity (Combating Loneliness One Conversation at a Time, MP Jo Cox Commission on Loneliness, 2017). Additionally, she observed that the Coronavirus pandemic of 2020, which forced people of all ages and demographics into isolation, added significantly to the public health issue previously recognized by the government in those countries. She further differentiated between "transient" and "chronic" loneliness (Williams, 2022, p. 17). The former type, explained Williams, is one that is experienced by all individuals and acts as a signal to address qualitative or quantitative needs for social interaction, much like hunger or fatigue. If these needs are not met, however, then the

second type of loneliness can occur. In this chronic type of loneliness, individual risk of heart disease and stroke increase by 29% and 32%, respectively. King (2018) also provided information about the physical side effects of loneliness, explaining it is related to higher blood pressure and cholesterol rates, as well as weight gain. Furthermore, King noted that loneliness is responsible for a 26% increase in premature death, which she compared to smoking 15 cigarettes per day.

Behavioral Component

Behavioral problems, including smoking or other substance abuse and a sedentary lifestyle, may also be bi-products of loneliness (Mund et al., 2020). In addition, Mund et al. found loneliness may have trait-like characteristics, much like personality, suggesting some individuals will be consistently lonelier than others. They reviewed research that took into consideration interpersonal characteristics at various stages in the life span and their subsequent impact on loneliness. For this meta-analysis, they reviewed 75 longitudinal studies that utilized specific measurements of loneliness, in addition to meeting other criteria for empirical psychological research. They also subdivided the research into age groups across the life span from six to 80.1 years or older. Multiple potential moderators of loneliness were identified, including cohort, gender, type of loneliness, geographic location, and type of assessment utilized to measure loneliness.

Mental Component

When it comes to the mental component, loneliness can limit development of problem solving and identity (Hemberg et al., 2021) and can also lead to hypervigilance and suspicion of others (Williams, 2022). As part of a larger study on the experience of loneliness among adolescents, Hemberg et al. (2021) recruited 15 participants between the ages of 17 to 30 from a

Finnish university. They conducted semi-structured interviews focused on mental health, loneliness, and childhood trauma. Per their hypothesis, Hemberg et al. found those individuals who intentionally chose to spend time alone felt positive about this experience and were less likely to report feeling lonely. Those who did not willingly seek out solitude, however, reported higher levels of depression, anxiety, physical side effects, and stress. The first group welcomed their solitude because it fostered creativity, rest, time to think, and a chance to focus on personal needs. The second group felt increasingly left out, isolated, and ashamed, turning their loneliness inward until it created a sense of self-loathing. Hemberg et al. suggested that normalizing alone time as a developmentally appropriate and personally constructive experience could help to change one's perspective of loneliness.

Emotional Component

Emotionally, Salo et al. (2020) discovered that loneliness often leads to low self-esteem, withdrawal from others and social activities, and heightened depression or anxiety. In their longitudinal study of 318 Finnish children in the fourth through sixth grades, Salo et al. built upon existing research that distinguished between social and emotional loneliness and examined how generational patterns of loneliness may be affected by gender. Their aim with this two-dimensional approach was to recognize the gender-specific influences on social and emotional loneliness, as well as to identify evidence-based supports for the entire family system. The children completed a self-report Likert scale questionnaire regarding their experience of social and emotional loneliness five separate times over the course of a two-and-a-half-year period. Parents (275 mothers and 246 fathers) of these children completed a separate assessment regarding their experience of loneliness at the initial starting point. Salo et al. discovered that both types of loneliness in children often lead to depression in later years. Since children develop

both social and emotional attachment within their family context, Salo et al. concluded that awareness and support during the early years is critical.

In her interactions with patients, Williams (2022) discovered that many individuals report not wanting to burden others, so instead of connecting with friends, family, or co-workers, they withdraw further and their symptoms of isolation worsen. Some of these symptoms, according to Williams, include depression, sleeplessness, lack of personal care, avoidance of others, and even suicidal ideation. Additionally, Williams observed these individuals often feel unsafe, suspicious, anxious, or overly self-conscious because of their increased isolation and loneliness. Franssen et al. (2020) explained that relationally, loneliness exists when there is a discrepancy between actual and perceived relationships, which then creates distress for the individuals experiencing it.

Spiritual Component

Finally, the spiritual component of loneliness has been described as a sense of despair and questioning of one's purpose (Achdut & Refaeli, 2021; Williams, 2022). Achdut and Rafaeli (2021) observed this is a direct result of undesired solitude, which can stem from discrimination, social anxiety, or a lack of belonging to social networks, such as schools, athletics, church organizations, or other age and peer related groups.

Social Monitoring, Emotional Intelligence, and the Loneliness Cycle

Ironically, loneliness often increases the behavior of social monitoring, which Pearce et al. (2022) described as an awareness of one's own emotions, as well as those of others through reading social cues and facial expressions. Despite the increased ability of many individuals experiencing loneliness to be better attuned to the social cues and emotions around them, they often fail to make successful social connections because they "choke" under the anxiety associated with initiating contact. As a result of this "choking," individuals are prone to isolate

themselves even further and continue to experience the cyclical pattern of loneliness and its various components.

The studies of Davis et al. (2019) and Achterbergh et al. (2020) observed a similar paradox when it comes to the relationship between loneliness and depression. Among their results of studying emotional intelligence and its correlation with increased levels of depression and anxiety resulting from loneliness, Davis et al. (2019) found that increased emotional intelligence often maintained the feelings of depression and loneliness. They examined a sample of 213 children in the United Kingdom with demographics representative of other children across the UK and a mean age of nine years old. The children completed self-report assessments about their experience of depression and loneliness on two separate occasions within a 12-month interval. In addition to the above finding, Davis et al. also learned that when children are taught emotional intelligence at an early age, it can help to reduce loneliness and its related feelings of depression and anxiety. Emotional intelligence in this instance is defined as the ability to think about and process one's emotions and not to internalize the negative impact of certain life events, including loneliness. Preece et al. (2021) refers to this practice as emotional regulation. When these skills were modeled and taught during the early childhood years, Davis et al. noted fewer instances of depression and loneliness later in the life cycle.

According to the Achterbergh et al. (2020), there is a cycle of mental health problems, withdrawal, and loneliness that can fuel the symptoms of depression and loneliness further. They conducted a meta-analysis of 14 qualifying studies of individuals between the ages of 11 to 30 in order to gain a better understanding about this cycle. Among the studies they examined, there were 388 total participants. Through a process of thematic analysis, Achterbergh et al. identified four themes, which begin with an individual's decision to withdraw from social interactions due

to various mental health issues, including depression. Despite wanting social connection, these individuals also often choose not to disclose their feelings to others, which leaves them feeling further isolated and misunderstood in their experience. Thus, ensues the paradoxical interplay of loneliness and a desire for social connection, a phenomenon described by Achterbergh et al. as a "vicious cycle" (2020, p. 16).

Loneliness Across the Lifespan

Loneliness is a phenomenon that occurs across the lifespan and is strongly predicted by the goals and expectations of each life stage (Franseen et al., 2020; Mund et al., 2020). Examples include failure to bond or thrive in infancy, behavioral problems or separation anxiety in childhood, self-doubt or suicidality in adolescence, empty nest syndrome in middle adulthood, and isolation and loss of meaning among the elderly. In their cross-sectional study of 26,342 Dutch adults, ages 19 to 65, Franssen et al. (2020) asked participants to complete self-report questionnaires about their experience of loneliness over the course of four months. During this time, participants responded to questions about loneliness as it correlated to three other factors, including demographics (education, gender, marital status, employment status, etc.), social factors (frequency of interaction with family and friends, volunteer work, community involvement, etc.), and a variety of physical health factors. Franssen et al. discovered that each age group experiences social or emotional loneliness in ways that are specific to that stage of life and development. Similarly, Kaur and Kaur (2021) noted that, particularly in middle adulthood, feelings of loneliness can develop when one season or purpose has come to an end and individuals are grieving this loss or transition. They explained there are a variety of significant changes occurring during this stage of the lifespan which require special attention when it comes to understanding how they contribute to feeling isolated and lonely. For example, in their study

of 50 Indian parents who were between the ages of 45 to 65, participants had launched a child to higher education or employment within the previous one to two years and rated high on loneliness on their self-report assessment of Empty Nest Syndrome.

Ozcan et al. (2021) observed in their study of 197 women during the menopausal years (40 to 55) that many women report physical changes (including menopause), may launch children to college or professions (empty nesters), and often shift careers. They also begin to reevaluate their roles, identity, and future goals, in addition to reflecting on their life accomplishments thus far. According to Liu et al. (2022), Chinese parents of adult children who had migrated to other Chinese cities, known as migrant elderly following children (MEFC), also reported feeling lonely because of their changing role and separation from their friends and community activities. Three stages of cluster random sampling were conducted in Jinan City and 656 adults over the age of 60 who had followed their children were selected. Loneliness and sense of belonging were measured with Likert scale questionnaires and demographic details were included as covariables. Liu et al. found that higher rates of loneliness were associated with a decreased sense of belonging and the type of migration only acted as a moderator when individuals relocated from one province to another and not within the same province.

Additionally, in their meta-analysis of 75 longitudinal studies conducted in Asia, Australia, Europe, and North America, Mund et al. (2019) found that different stages across the lifespan correlated higher with loneliness than others. Although many of the adults possessed individual traits that remained somewhat stable in regards to loneliness over a one-year period, this fluctuated more as time went on and was influenced by moderating factors, such as gender (higher rates of loneliness reported among females), birth cohort, and location. These three studies support Franseen et al. (2020) and Mund et al.'s (2020) above discovery that loneliness is

largely determined by the life stage an individual is in, as well as the goals or expectations associated with that specific stage.

Individual Factors of Loneliness

In addition to the above life stage changes, Mund et al. (2020) explained that cohort, gender, personality, and geographic location can also affect loneliness. Individual variances for loneliness often become increasingly stable from childhood into late adulthood, although loneliness as a phenomenon is known to be stable throughout the lifespan. Additional factors include what Salo et al. (2020) termed as the generational affect, which has to do with the transference of loneliness between the generations as a result of social and emotional attachment within the family context; the temporary nature or chronicity of loneliness (Williams, 2022), and Smartphone or social media usage (Wetzel et al., 2021). According to Wetzel et al. (2021), this last factor correlated with higher rates of feeling socially isolated and not fitting in, often causing individuals to withdraw and feel lonely, depressed, or anxious. This study focused on the connection between Smartphone app usage and self-reports of loneliness and well-being. They collected data from 364 volunteers ranging in age from 18 to 78 through the CORONA HEALTH APP. Participants completed questionnaires regarding their phone app usage, age, gender, previous diagnosis of a mental health condition, and a variety of other demographic variables. In comparison to data collected prior to COVID-19, self-reported incidence of loneliness in this study was much higher, which the authors hypothesized could have been due to the prolonged isolation of the pandemic. It is also worth noting that Wetzel et al. chose to collect data from real time Smartphone app usage, as they noted that previous self-report studies have often been conducted in retrospect, which can contain errors due to memory and recollection. Individuals completing self-report assessments or surveys may also be concerned about having

socially acceptable answers, thus creating potential response bias. To avoid these issues, Wetzel et al. designed a study to collect data from Smartphones about usage of apps, such as Facetime or texting, or duration of sleep. These observations about quantitative-only self-report studies further support this author's decision to conduct individual interviews with participants to better understand their lived experience of loneliness during the menopausal years.

Finally, Maes et al. (2019) conducted a meta-analysis of the role of gender in loneliness. They coded results based upon age, loneliness type, socioeconomic status, physical or mental health problems, geographical location, ethnicity, and publication year. Many of these factors were not significant predictors of loneliness; however, age, geographic location of the sample, and year of publication did have significant effects on loneliness. An individual's age was the primary moderator of gender experience on loneliness.

Vulnerable Populations and Loneliness

Although loneliness is not unique to the present time, many researchers believe it has reached epidemic proportions since the COVID-19 pandemic of 2020. Arbuckle (2022), Gibbes (2022), and McComb et al. (2020) agreed that loneliness is a phenomenon experienced across history and the lifespan, yet the combination of a global pandemic, political turmoil, war, racial tensions, economic hardships, and opposing belief systems have created a crisis of loneliness. Vulnerable populations are especially at risk for suffering the negative side effects of loneliness, particularly when shame is attached or one's cultural and family backgrounds do not recognize or support the expression and treatment of this experience.

Black women have historically been part of these vulnerable populations. For instance, Nelson et al. (2022) used path analysis to examine how social isolation and gender identity, or schema, influenced loneliness and depression. In their study of social isolation and racial and

gender discrimination among 271 Black women in America (ages 18 to 70), Nelson et al. found that women who were socially isolated experienced higher levels of depression, as well as negative emotions associated with a perceived obligation to help others. Conversely, women who resisted vulnerability and emotional suppression (known as the Superwoman Schema) were less likely to isolate and feel depressed. Participants completed self-report Likert-type questionnaires designed to measure a variety of factors, beginning with the Superwoman Schema (S-SWS-Q, 2019), which included statements such as "I try to present an image of strength" and "I keep my feelings to myself" (p. 4). In addition, the women in this study completed the Center for Epidemiologic Studies Depression Scale Revised (CESD-R, 2004), the Connor–Davidson Resilience Scale (CD-RISC-25, 2003), the UCLA Loneliness Scale (Version 3, 1996), and the Multicomponent In-Group Identification Scale (2008), which measures gendered racial centrality. Once descriptive statistics were conducted with the data, results of this study suggested that a sense of self was central to overcoming the obstacles related to loneliness and possibly served as a protective factor against the pervasiveness of loneliness.

The findings of Raque-Bogdan (2019) conferred with those of Brown and Munson (2020) who commented on the correlation between social isolation and various mental, emotional, and physical side effects, including a higher mortality rate. They explained that within the family system, one individual's experience of loneliness can affect others within the system. Luoma et al. (2019) also observed that children of mothers who were lonely while pregnant were more likely to experience internalization problems, such as anxiety, in adolescence. Additionally, they found this loop of loneliness between the generations often reinforced itself when left untreated. Pineros-Leano et al. (2021) found similar results in their study of Latina mothers, noting that

children of depressed and lonely mothers were at higher risk of developing a variety of mental and emotional difficulties.

Like Black women, Latina mothers in the United States are also considered especially vulnerable to isolation and depression. According to Pineros-Leano et al. (2021), this is due, in part, to their minority status and potential obstacles to care and support as a result of language or education barriers and current discrimination against Latinx individuals. In their individual interviews with 30 Latina women recruited through purposive sampling from a community WIC office, Pineros-Leano et al. asked women five questions regarding their experience of loneliness and depression. As a result of these interviews, they identified three themes centered around the experience of being female in a society with certain expectations and pressures for women and mothers. These included a tendency to downplay or normalize one's experience of isolation, depression, and sadness, as well as a lack of social support and gender roles that inhibited disclosure of one's feelings. The women in this study described feeling sad and lonely after giving birth, being separated from their own mothers who lived far away, and feeling they were unable to properly grieve the loss of family members due to their inability to travel home for funerals. These events, in addition to limited social connections while living in a foreign country, added to their sense of isolation and subsequent loneliness and depression. In fact, many of these women, according to the interviews conducted by Pineros-Leano, were surprised to learn during the study that they were indeed depressed because they had normalized their feelings in order to cope and carry out their duties as mothers.

In their cross-sectional design of mothers with infants and young toddlers, Arimoto and Tadaka (2021) studied support systems to reduce the negative side effects of loneliness and isolation on young mothers. Specifically, they focused on how individual factors, such as mental

health or feeling incompetent, impacted loneliness. Additionally, they examined how family support and community connection either prevented or fostered loneliness and social isolation. Arimoto and Tadaka administered anonymous surveys to 492 mothers with infants and young toddlers visiting a community health clinic in Yokohama City. Participants answered Likert scale questions regarding their experience of loneliness and social isolation. Based upon their response to the isolation questionnaire, participants were then divided into two separate groups classified as isolated and non-isolated. Demographic information, details about their internal support systems, experience of motherhood and number of children, employment, and child care were also studied as independent variables affecting loneliness and social isolation. Among the isolated mothers, there was a higher prevalence of feeling inadequate or worrying as a mother. In addition, these women were much less likely to engage with neighbors or to access community resources. Overall, reports of higher loneliness correlated with social isolation. As far as individual factors were concerned, those mothers who were uncertain about meeting daily needs or who lacked supportive partners were also more likely to feel lonely.

Ross et al. (2021) found similar themes of social, familial, and cultural isolation among wives of National Guard and Reserve service members. Due to prolonged deployments, relocations, separation from family, and the unpredictable nature of recurring deployments since the wars in Afghanistan and Iraq began in the early 2000s, many mothers of young children have been negatively impacted by deployment-related stress (DRS). Ross et al. explained that one of the key components to military families succeeding is the emotional health of the entire family system. This is generally supported through social connection, which takes the form of tangible help, empathy, social activities, suggestions for adapting to a new environment, and so forth. Without this social support, therefore, these women become increasingly isolated and lonely.

This is especially true for mothers of young children, as this tends to be a time where women report feeling more isolated, in general.

In this way, the women studied by Ross et al. (2021) were not unlike the cancer patients and Latina and Black women mentioned above in that social isolation was a key player in their development of loneliness. This also rang true for the mothers in Gadban and Goldner's (2020) study of 80 Israeli Arab women living in polygamous families. According to Gadban and Goldner, polygamy in Israel typically involves one man married to two women, although some men may have three or four wives. These marriages, as observed by Gadban and Goldner, are often known for their abusive nature, which leads to shame, isolation, depression, feelings of inadequacy, and hopelessness for the women involved. Through the use of narratives and drawings, the women were asked to express their feelings about five topics, including their homes, the fathers in their relationships, and their current level of distress related to these things. Out of the 80 women interviewed, 16 (20%) had positive reports of their experience, while 64 (80%) had negative reports. One of the themes that emerged through this process was the sentiment that a woman's husband no longer mattered, only the happiness and welfare of her children. Many of these women felt powerless to form a healthy or loving relationship with their husband and expressed feelings of jealousy toward the other wives, as well as feelings of fear, confusion, and loneliness. Of note for the present research study, however, is how some of the women in Gadban and Goldner's study chose to cope amid their isolation and loneliness. In one woman's drawing, for example, she depicted a beautiful tree in bloom and shared that despite her stressful life, she envisioned herself as a tree planted firmly and growing. She went on to describe how the tree gave life and remained strong for her children. A similar drawing by another woman expressed hope and the desire to continue living and being present for her

children, despite the limitations of her marriage. Some of the Latina mothers in Pineros-Leano et al.'s (2021) study shared a similar sentiment in that they did not want to spend their time being sad and chose instead to focus on parenting and taking care of their home.

Menopause and Loneliness

When it comes to the population of interest for this research proposal, women during the menopausal years often report feeling isolated and alone. During menopause, explained Ozcan et al. (2022), many women grieve the loss of motherhood, physical looks, and years gone by. These feelings of loss often present in the form of depression, self-loathing, low self-esteem, decreased libido, withdrawal, inability to sleep, and a variety of other physical symptoms. Ozcan et al. further explained that hormonal changes during menopause can create an increase in cortisol, which is a stress-related hormone. This change, in addition to the physical and emotional changes occurring during menopause, can wreak havoc on interpersonal relationships due to the physical discomfort of sexual intimacy and lower self-esteem that is often a biproduct of these changes. To make matters worse, Ozcan et al. noted that increased stress and depression negatively impact menopausal symptoms.

Minkin (2019) observed that many of the physical changes experienced during this phase of life are responsible for creating the stress, anxiety, and depression described by Ozcan et al. (2022). For example, 20% of women in the United States experience severe vasomotor symptoms, more commonly known as hot flashes or night sweats, which are caused by decreased levels of estrogen that regulate temperature within the body. Another 60% of women will experience moderate vasomotor symptoms and a remaining 20% report very little to no discomfort in this regard. Additionally, a variety of urogenital symptoms can develop, which, in turn, can affect a woman's desire for (libido) and comfort with sexual intercourse. Libido, in

general, is known to decrease during menopause, as well as weight gain and various hair and skin changes, which Minkin and Ozcan et al. (2022) explained can lead to feelings of insecurity, unattractiveness, self-blaming, and relational strain. Psychological and emotional problems are also more likely to develop during this time due to the physical and hormonal changes, which can lead to irregular moods, heightened emotionality, anger, and sadness. Memory fog, inability to focus, muscle pain, bone loss, and cardiovascular issues are also prominent during the menopausal years.

Added to the physical changes of menopause is the sensation that many women feel they no longer have a significant purpose or that they have become invisible as their child-rearing days come to an end and children are launched from the home. McComb et al. (2020) referred to this phenomenon as a "double jeopardy" because of the simultaneous experience of loneliness and feeling that one no longer matters to others. They found that feeling insignificant and powerless to change one's social situation contributes to loneliness and depression. Using the General Mattering Scale (GMS), a five-item Likert-type self-report questionnaire, McComb et al. measured participants' perception of how much they mattered to others. The strongest predictor of loneliness in this study was a perceived sense or fear of not mattering to one's friends. It is important to note that perception did not always match reality, a factor which is reiterated in many studies of loneliness. In fact, McComb et al., Preece et al. (2021), and Oles et al. (2020) each pointed out that it is possible to feel lonely when not actually alone and, conversely, to feel satisfied in solitude. According to these authors, perception and self-talk are integral to determining how individuals interpret being alone. Again, Ozcan et al. (2022) explained that while a woman's sense of loss due to role changes, launching of children, or physical differences may not be life-threatening, it is her perception of how these phenomena affect her femininity

that is most vital. When women during the menopausal years become fixated on these changes and interpret them as signifying uselessness or irrelevance, then depression and loneliness are more likely to occur to the point of manifesting in physically harmful and potentially deadly effects.

According to Luoma et al., (2019), who conducted a longitudinal study of 356 Finnish mothers recruited from maternal health clinics beginning in 1989, loneliness and depression are separate phenomena that often co-occur throughout the lifespan of motherhood. By collecting data at three distinct times over their child's lifetime (during pregnancy, between ages 8 and 9, and between ages 16 and 17), Luoma et al. discovered a higher incidence of loneliness and depression at the final data collection stage among those mothers who had reported similar feelings during pregnancy. However, while loneliness was often related to the physical challenges of pregnancy during the first stage, it was later associated with the mother's overall dissatisfaction with life and her current romantic partnership. This finding is similar to those of Ozcan et al. (2022) and McComb et al. (2020) who observed that many women during the menopausal years suffer acute loneliness, anxiety, and depression due to the role changes occurring during this stage of life and the feeling that their significance, or meaning, has somehow diminished as their children age and prepare to launch from the home.

In their study of middle-aged Iranian women (age 40-60 years), Abedi et al. (2020) observed that women who had launched their children from the home to college, careers, or marriage experienced a high rate of loneliness, as measured by the UCLA Loneliness Scale. This loneliness is often prolonged because the average life expectancy after menopause has increased, leaving women without a sense of purpose for an even longer period. One of the ways in which loneliness was exhibited for the women in Abedi et al.'s study was related to sexual desire and

function. Sexual function and fulfillment had an inverse relationship with loneliness, in that they increased as loneliness decreased. For these women, there was a significant correlation between empty-nest, menopause, and loneliness. Additionally, Abedi et al. cited previous research noting the susceptibility of this population of women to form brain lesions, experience cognitive difficulties, develop major depression, and a variety of other physical or psychological disorders. A few factors acted as mediators on the negative side effects of loneliness for these women, however, which included economic stability and having a job that served as a social outlet and offered purpose.

In a separate study of Iranian women aged 40 to 60, Yazdkhasti et al. (2019) found that some women identified their own coping strategies to deal more positively with the inevitable changes of menopause. In fact, some even reported a sense of relief at no longer having to deal with the challenges associated with menstruation and gave themselves permission to embrace the next season of life without the concerns of child-rearing. Additionally, Yazdkhasti et al. learned that women found it helpful to redefine the definitions of femininity, self-care, and identity through a process of self-retrieval. Self-retrieval in this context includes four elements: the development of self-care, seeking empowerment, practicing cognitive strategies, and obtaining treatment. The women in Yazdkhasti et al.'s study employed various methods to achieve these elements, including completing their education, utilizing homeopathic remedies, and practicing faith. These intuitive practices enabled the women to pivot their focus from the negative aspects of menopause to one of empowerment and self-improvement.

Practices That Mitigate Loneliness

The idea that an individual may alter their experience of loneliness by changing their perspective of current circumstances is one the present research study intends to explore further.

For instance, what skills and coping mechanisms have these women employed to mitigate their experience of loneliness and even to accept solitude as an alternative to feeling left out or overlooked?

Solitude

There exist a variety of negative mental and physical side effects of prolonged and unwanted loneliness and solitude. Teneva and Lemay (2020) noted the significant correlation between loneliness and psychological distress, as well as the connection to social cognition in that loneliness often influences individuals' interpretation of and response to social interactions and perceived isolation. In their study of 610 adults, ages 18 or older, who were recruited through a convenience sample of individuals receiving peer-supported services. Jenkins et al. (2022) examined the relationship between isolation and serious mental illness (SMI). They discovered a higher prevalence of bipolar disorder, schizophrenia, and other affective or mood disorders among those who were socially isolated. Unfortunately, this relationship was bidirectional in that mental illness may have caused individuals to withdraw socially and to be shunned or excluded because of their mental illness. A key component to this experience, according to Jenkins et al., had to do with one's perception of these experiences. They clarified that being alone does not necessarily equate to feeling lonely, a conclusion that was also supported by Thomas and Azmitia (2019) and Arbuckle (2022). These studies suggest that an individual's perception of being alone and his/her willingness to engage in times of solitude act as moderators on the negative experience of loneliness.

Elmer et al. (2020) designed a study to examine the directionality of depression related to loneliness. To do this, they posed two steps of a longitudinal comparison. The first was to examine whether baseline depression predicted later solitude inertia and the second examined

whether baseline solitude inertia predicted depression at post-measurement. The authors of this study defined solitude inertia as an individual's tendency to linger in alone time. While depressive symptoms were not found to be correlated with socialization, they were correlated with time spent alone. Social isolation, which often resulted in solitude inertia, reinforced depression, but not visa-versa, thereby determining the directionality of this relationship. The authors concluded that a balance between social interaction and solitude was best for preventing depressive symptoms from developing. In a separate study conducted by Birditt et al. (2019), they decided to expand upon existing definitions of solitude and examined whether social context had a bearing on subsequent well-being. Specifically, they asked if daily solitude was associated with daily emotional well-being and whether the relationship between solitude and emotional well-being varied by the quality of social networks. Like Jenkins et al.'s (2022) findings, a key observation in Birditt et al.'s study of individuals over the age of 65 was that one's perception of solitude, whether wanted or not, was partly influenced by the overall quality of his/her social connections and relationships. It suggested that if these connections were positive, for example, then spending some time in solitude was more welcomed and did not necessarily lead to negative affective symptoms. Birditt et al. also noted the opposite could be true, however, in that feeling isolated or disconnected socially could make solitude more painful and contribute to poor emotional well-being.

Thomas (2023) conducted a qualitative study of 14 adults whose median age was 49.5 to learn what strategies enabled them to engage in solitude in ways that were deemed psychologically and emotionally beneficial. The operational definition of solitude used by Thomas is one this author applied to the present study. It defined solitude as an intentional practice pursued for its inherent benefits, such as rest and the pursuit of individual interests. In

this way, Thomas and Azmitia (2019) noted that solitude is intrinsically motivated. Thomas (2023) clarified that constructive and healthy solitude is one that is enjoyed and meaningful to its participant, whereas negative solitude is one that is not sought after, may be the result of unwanted circumstances, and results in feelings of sadness, depression, and anxiety. In other words, when solitude is chosen it is perceived positively (Mund et al., 2019). Leontiev (2019) also explained that solitude is necessary for cognitive and emotional development. In addition, it allows individuals to pause, reflect, and take ownership of their positive and negative responses to various situations.

Social Connection

In addition to a healthy understanding of solitude and the perspective taking discussed by Latina mothers (Pineros-Leano et al., 2021) and the wives in polygamous marriages (Gadban & Goldner, 2020), creating a supportive community is also instrumental to breaking the cycle of isolation and loneliness. For example, in a program designed to connect older individuals within the LGBTQ+ community with “friendly callers” who checked in on them regularly and functioned as a form of social support, Brown and Munson (2020) observed that isolation and its many related components were reduced not only for the elders, but also for many of the callers (p. 4). These findings led the authors to conclude that the reciprocity involved in social interactions was also a critical component to addressing loneliness among those who were isolated due to lifestyle, age, position in life, social or historical events, and so forth.

Reciprocity was also an element recognized in the study performed by Ross et al. (2021) who found that wives of military personnel were more likely to feel lonely when they lacked the support and interaction of other military families. This theme of reciprocity became especially apparent during the COVID-19 pandemic of 2020, which impacted individuals and families

across the world. Valliani and Mughal (2022) studied people living in societies affected by COVID-19 and discovered that many expressed disbelief, denial, anger, and longing for previous times. Additionally, they discovered that acceptance of the situation led to decreased anxiety and eventual integration of the losses created by the pandemic into a new normalized reality. Valliani and Mughal validated grief as a normal and appropriate response to change in general, which often involves some type of loss, such as the loss of routine, identity, or a relationship (all of which occurred during the pandemic). These losses, explained Valliani and Mughal, can result in feelings of sadness, worry, doubt, uncertainty, and shifts in sleeping or eating habits. Pathology develops when these normal emotional responses remain unprocessed and people become stuck, thus putting them at greater risk for depression, anxiety, eating disorders, substance abuse, academic difficulties, and suicidality.

The period of the COVID-19 pandemic is not unique to the experience of loneliness; however, it is extremely helpful in allowing psychologists and researchers an opportunity to examine the direct impact of social isolation and subsequent loneliness on the developing emotions and psyche of children and adolescents. According to O'Shea et al. (2022) anxiety, depression, suicidal ideation, and mental health-related hospitalizations were significantly more frequent and had a longer duration among children and adolescents throughout the pandemic. While much of this was attributed to the insecurities of health, food, employment, financial resource, access to education, and so forth, O'Shea et al. noted the forced isolation also led to fewer eyes and ears which would normally be looking for and recognizing the signs of mental illness in schools or other public settings. Knopf (2020) also observed that the forced lockdown and social distancing required during the pandemic acted as a sort of petri dish for uncertainty, boredom, and lack of connection and routine. As a result, many children and adolescents who did

not previously suffer from depression or anxiety, as well as those who did, were experiencing heightened symptoms.

This data is significant in that it offers insight into the nature of loneliness, how it is developed, and its possible negative side effects. For example, Knopf (2020) noted that in previous health pandemics there was a fivefold increase in depression and post-traumatic stress among children who were forced to endure social isolation. Knopf further observed that social isolation in and of itself, however, did not necessarily equate to loneliness. It was when these two components were present together for a sustained period that negative mental health side effects, such as depression and anxiety, seemed to occur. Knopf concluded that among adolescents who typically seek out increased alone time while also desiring greater social connection, the element of being forced into isolation was significant. It was also the perception of isolation that affected adolescents' experience of loneliness. Because loneliness has to do with the perceived differential between the social connection one desires and the actual quantity and quality of those connections, adolescents suffered greater emotional pain when they had no control over the isolation.

Like Knopf's (2021) findings, O'Shea et al. (2021) also discovered an increase in mental health related emergency room visits for children suffering from anxiety, depression, and suicidality during the pandemic. Many parents reported a marked change in their child's mental health presentation during this time, with one study indicating that 31% of parents reported their child's mental and emotional well-being was significantly worse than before the pandemic. Interestingly, Raw et al. (2021) found mixed results in the initial months of 2020 following lockdown in the United Kingdom in which some adolescents reported an improvement in their mental health while others experienced a decline. Although researchers are still investigating

possible causes for this discrepancy, initial results showed that children and adolescents of families who bonded and spent increasing amounts of quality time together during the pandemic reported fewer incidences of mental health problems. For some, the separation from school drama, bullying, and pressures to fit in were a welcomed reprieve in their experience of social anxiety and stress. Furthermore, those individuals who relied heavily upon their social network to feel accepted or connected felt increasingly isolated and depressed as a result of the lockdown. This research is significant in allowing psychologists to better understand how loneliness can develop into painful feelings of disconnection when the isolation that breeds it is not welcomed or is sustained for too long. In fact, Knopf (2021) and Salo (2020) found that the duration of an adolescent's loneliness was a key factor in the development of depression and anxiety.

Reflection and Perspective Taking

Although some research has focused on the development of new interventions aimed at alleviating loneliness, Tagomori et al. (2022) and McKenna-Plumley et al. (2021) discovered that many people already possess the skills required to combat loneliness and its negative side effects. In their study of socially and economically disadvantaged young people in London, for example, Tagomori et al. observed that individuals utilized a variety of coping skills to deal with loneliness based upon their perceived effectiveness and availability of supports. These included social withdrawal and avoidance, seeking support from others, reflection or perspective-taking, practicing faith or focusing on self-growth, and staying occupied. There were some gender differences in these coping skills, yet most expressed that an authentic emotional connection with another was most meaningful in reducing loneliness. In their study of individuals impacted by the COVD-19 pandemic, McKenny-Plumley et al. interviewed eight individuals who recognized that their feelings of loneliness were directly related to the constraint of lockdown and its

associated emotions. Coping mechanisms for these individuals included recognizing that their experience was shared across the globe, engaging in positive self-talk, and getting creative with social connection and distractions. What these two studies had in common was their emphasis on individuals being resourceful and identifying their own positive means of coping with loneliness.

Addressing thoughts and perspectives, adjusting daily habits, and brainstorming creative ways to engage with others (despite one's circumstances) gives hope that individuals can be taught these skills and apply them in practical ways. The study conducted by Foster et al. (2020) further demonstrated that loneliness can be alleviated in simple and time-saving ways. In this mixed-methods study of 10,643 participants, Foster et al. examined whether a social prescribing program would effectively reduce the negative symptoms of loneliness. Participants took part in a 12-week program and the authors examined pre- and post-treatment data over a two-year period as part of the quantitative component. The qualitative aspect consisted of examining semi-structured interviews with participants and support persons regarding the efficacy of this intervention, as well as the overall social impact of reduced loneliness. A significant reduction in loneliness, as measured by the UCLA Loneliness Scale, was found in many participants who received support. Additionally, many individuals changed their status from "lonely" to "not lonely" due to the intervention received (Foster et al., 2020, p. 1443). This support was most significant in helping participants to gain self-confidence, re-establish daily routines, engage with their community or in a hobby, and feel energized. Although there were some inherent challenges to the social prescribing method, as noted by Foster et al., such as inconsistency of follow through with appointments and quality of support volunteers, the model demonstrated the ability of social connection to reduce individual loneliness, which can then have profound effects on a community at large.

Building social connection to reduce loneliness was also observed in the study conducted by Batcho (2021). Batcho sought to learn from the accounts of Ukrainians who were displaced during World War II and how they employed nostalgia to cope with the traumatic events related to war. This included losing their home, culture, and identity, enduring all kinds of hardship, and feeling separate and lonely in their displacement. Batcho was curious to see if this coping skill could apply to similar modern experiences of loneliness, isolation, and disconnection and conducted a narrative analysis of documentation, which in this case consisted of three memoirs from Ukrainian individuals during World War II. Batcho's goal was to access stories that had not yet been shared with the world in order to learn from the storytellers' inner coping strategies of physical, emotional, and cultural survival. Each of the memoirs described how nostalgia created a sense of cultural unification and helped these individuals to maintain their identity amid being separated from loved ones, homes, culture, livelihoods, and so forth. This study asked four different research questions, the first of which had to do with how nostalgia might help to counteract disruptions to identity, cultural norms, and values. The second asked how nostalgia sustains identity. The third research question focused on the role of nostalgia in building community and finally, the fourth question focused on how nostalgia served as an adaptive survival skill. This study is significant to the study of loneliness in that it describes a unique type of loneliness: that of social and cultural separation and loss of community. To preserve their common heritage, survivors of the war in this study talked about their homeland, their shared experiences and values, and their hope for a return to peace by practicing nostalgia. This skill allowed them to persevere despite the sense of loneliness and isolation they experienced.

Physical Exercise and Perception

Lippke et al. (2021) expanded on this idea of social connection acting as a mediator on loneliness in their study of friendship and physical exercise and how they functioned as coping mechanisms against the isolation of lockdown during the COVID-19 pandemic. Utilizing a mixed-methods approach of quantitative and qualitative elements, the participants completed a self-administered self-report measure for the quantitative portion and participated in individual interviews for the qualitative piece. This study posed six research questions having to do with the impact and extent of said impact of exercise, sex, relationship status, living status, and friendship on the experience of loneliness during the lockdown. The primary research question, however, was whether physical activity related differently to loneliness prior to and during the pandemic. The authors found that times of change were especially difficult for the age group studied, ages 18 to 29. Also of significance was the lack of meaningful interaction with others, with the observation that virtual interaction was often not as meaningful as in-person. Physical exercise provided an outlet for feelings of loneliness, which prior to the pandemic included going to work for many participants. Perceived social support and quality of social interaction were also significant factors in reducing or avoiding the development of loneliness altogether. Once again, perception seems to be key when it comes to the development of depression and anxiety often associated with loneliness.

Khan et al. (2021) found similar results to those of Lippke et al. (2021) in regards to the impact of physical activity on loneliness. In their study of 12,133 youth, ages 12 to 17, 12% of those teens who were considered overweight also reported feeling lonely. In fact, Khan et al. observed an inverse correlation between the amount of physical activity, or sedentary lifestyle, and loneliness. They also observed that many sedentary activities, such as watching television or utilizing social media, increased the opportunity for cyber bullying, feeling left out or excluded

from social functions, and the prevalence of comparison to one's peers, all of which led to increased feelings of loneliness. Additionally, Khan et al. referred to previous research that demonstrates the many ways in which physical activity acts as a protective factor against social isolation, low self-esteem, and loneliness by providing opportunities to build self-confidence and social connection.

In Hwang et al.'s (2019) study, it was the combination of physical activity and perception of positive social connection that helped to decrease loneliness and its associated side effects. Hwang et al. conducted semi-structured interviews with 16 individuals (average age 76.6 years) regarding their participation in the "Walk 'n' Talk for Your Life" program (WTL), a free community-based program aimed at providing socialization and physical fitness for older adults. Although there were a variety of reasons for participant loneliness, including retirement, living alone, relocation to a new home, and difficulty forming a new community, one's perception of these factors and of other people's experience of similar situations was improved upon completion of the WTL program. Participants reported feeling increasingly motivated because of this program, as well as less alone, more supported when in need of help, and healthier overall. Of note was the perception that each of these things was better as a result of the WTL program.

Emotional Regulation, Mindfulness, and Self-Talk

Another key factor in addressing loneliness has to do with an individual's ability to practice emotional regulation. According to Galla et al. (2020), mindfulness is required to regulate one's emotions and is defined as "nonreactivity to difficult inner experiences" (p. 350). They clarify that in Western culture, nonreactivity is interpreted as the ability to regulate one's thoughts and emotions, as well as to maintain a stable attitude. Lerner (2015) adds to this idea by noting that within an individual's person-context relations, self-regulation is occurring as he/she

responds to and regulates his/her environment, which according to Relational Developmental Systems theory (RDS), is also responding to the individual. Galla et al. provide an important distinction to aid in understanding mindfulness. For example, mindfulness is not ignoring or avoiding one's problems; rather, it is the ability to "'take a step back from' difficult mental experiences and view them from a wider, more dispassionate and objective perspective" (Galla et al., 2020, p. 351). Furthermore, being mindful of events and emotions involves being consciously aware of not becoming reactive to them. Being mindful is therefore a nuanced skill learned through practice and successful navigation of stressful or difficult life events.

According to Preece et al. (2021), teaching individuals to regulate their emotional response to loneliness is significant in the overall reduction of negative symptoms. Regulation in their study included a decrease in blaming, rumination, withholding of emotions, and social withdrawal. It also included an increase in reevaluating one's circumstances, adjusting one's perspective of being alone, and engaging in meaningful social interactions. Preece et al. noted that previous studies focused primarily on two main components of emotion regulation, which are cognitive reappraisal and expressive suppression. The purpose of their study was to broaden the examination of additional emotion regulation skills and their variance with symptoms of loneliness. They did this by recruiting participants from an on-line research pool, known as Qualtrics. The sample consisted of 501 adults, 8% of whom were college students at the time of the study, with an overall mean age of 46.92 years. The sample was split nearly in half by gender and represented a diverse population from every region of the country and a variety of ethnicities. All participants completed demographic information as part of their anonymous on-line surveys, designed to measure loneliness and emotion regulation. Participants then completed four assessments designed to measure their perceived experience of loneliness and emotion

regulation skills. These included the UCLA Loneliness Scale, the Emotion Regulation Questionnaire (ERQ), the Cognitive Emotion Regulation Questionnaire (CERQ), and the Behavioral Emotion Regulation Questionnaire (BERQ). All assessments were self-report Likert-type scales. Using Pearson bivariate correlations, the researchers analyzed whether routine emotion regulation predicted loneliness. There was a significant correlation ($p < .05$) between loneliness and blaming others or self, ruminating, and catastrophizing, which were all classified as cognitive emotion regulation. Loneliness was also correlated with social withdrawal, acting out, and avoidance, which were classified as behavioral emotion regulation. There was not a significant correlation between loneliness and gender, but it did exist for age and lower education level. The researchers were surprised to find that those individuals who reported feeling lonely also tended to cope with emotion regulation tactics which resulted in further isolation due to withdrawal, suppression of emotions, and negative expression of emotions. These findings were consistent with other research studies that show a high correlation between individuals who are unhappy with their loneliness, yet participate in cognitive and behavioral strategies that often perpetuate this experience. Preece et al. suggested utilizing this information to guide interventions that teach individuals to decrease loneliness by decreasing negative behavioral and cognitive regulation strategies, such as rumination or withdrawal, and instead increasing positive emotion regulation strategies like reappraisal and seeking support.

Oles et al. (2020) added to the recommendations of Preece et al. (2021) by explaining the importance of one's inner dialogue, or self-talk. Oles et al. defined self-talk as "self-directed or self-referent speech (either silent or aloud) that serves a variety of self-regulatory and other functions" (p. 2). Self-regulation, they added, is an important component to this self-talk, as it determines the tone of an individual's self-talk, as well as their beliefs about their current

situation and subsequent behaviors associated with being alone or lonely. Oles et al.'s study focused on the relationship between self-talk and inner dialogue by comparing cross-cultural samples of two existing measurements designed to assess these phenomena. The first measurement was the Self-Talk Scale (STS), developed in the United States, and the second was the Internal Dialogical Scale (IDAS-R), developed in Poland. The designers of this study expected that those individuals who engaged in more frequent inner dialogue would also engage in more frequent self-talk. The strength of this relationship, they hypothesized, would depend on the type and subscale of both styles of interpersonal speech.

Oles et el.(2020) recruited two samples of college students, the first consisting of 181 master's level Polish students, ranging in age from 18 to 34, and the second consisting of 119 undergraduate psychology students in the United States, ranging in age from 18 to 29. Both men and women were represented in both samples. Participants completed the STS and IDAS-R individually or in groups of five to ten. The STS is a 16-item inventory about self-criticism, self-reinforcement, self-management, and social-assessment. The IDAS-R is a 40-item inventory which measures the frequency of internal dialogue, as well as eight sub-types, such as maladaptive or social dialogues. Data from both samples was compared and correlated. The United States sample scored higher on both measurements, which the researchers suggested could be a result of age and/or cultural differences. Correlations between the two types of internal communication were consistently in the moderate to strong range. Results demonstrated that self-talk is a significant component to inner dialogue, the first being defined as statements to self, such as "Try again," and the latter resembling more of a conversation between two parts of the self, such as arguing both sides of an issue or attempting to weigh pros and cons. Of additional importance was the finding that self-esteem helped to support internal dialogue and

self-talk. Furthermore, different kinds of inner dialogue supported reflection, self-awareness, the maintenance of social bonds, and the reduction of loneliness.

Spiritual Practice

Additional factors that help to reduce the negative mental and emotional side effects of loneliness include spiritual connection, family support, and wisdom (Arimoto & Tadaka, 2021; Paredes et al., 2021). French et al. (2022) cited multiple studies indicating a correlation between religion and loneliness, noting that spiritual practice is one of the most effective coping skills in combating the negative effects of loneliness. French et al. assessed 564 teenagers of both genders in the 10th grade and reassessed 446 of the same individuals one year later in the 11th grade. They collected self-report data from the participants regarding religious involvement or practice and positive religious coping, which included prayer, asking for forgiveness, and perspective taking. In addition, participants provided self-reports regarding their externalizing behaviors, such as substance use or problems with peers, and their experience of loneliness. This study, which focused on Indonesian Muslim adolescents, resulted in less negative self-report due to loneliness when religious belief and practice were a regular part of their life habits. Furthermore, French et al. (2022) found that regular practice of spiritual coping mechanisms was negatively correlated with loneliness. Spiritual coping mechanisms in this study referred to emotional regulation, prayer, and asking God to reveal his purpose in a particular situation or struggle. In addition, the lack of this practice predicted the shift in experience of loneliness (and vice versa) from 10th to 11th grade. As the authors expected, those teens who possessed an active religious life were also less likely to participate in externalizing behaviors. They acknowledged this was due, in part, to the rules and expectations associated with Muslim religion and culture.

French et al. (2022) suggested spiritual practice and coping mechanisms may help to reduce loneliness in adolescents by helping them to accept hardship**,** teaching patience, encouraging teens to express gratitude**,** teaching them to remain hopeful, and providing comfort through a relationship with God. This is especially instrumental in that it creates an attachment relationship, which Davis et al. (2019), French et al., and Salo et al. (2020) agreed is primary to navigating periods of being alone throughout the life cycle.

Like French et al. (2022), Paredes et al. (2021) found that spirituality acted as a protective factor for elderly individuals living in care facilities, particularly when their close friends and peers passed away. Their study found that faith protected against loneliness by providing a sense of purpose or meaning, not feeling threatened by solitude, and being content in one's own company. Additionally, wisdom, which was a bi-product of faith and life experience, acted as a mediator on loneliness and allowed residents to reflect, feel gratitude, express compassion, and maintain a balanced perspective of their situation and life, thereby decreasing their experience of loneliness.

Borawski (2022) found that an individual's positive orientation (POS) toward loneliness allowed him/her to feel a greater sense of meaning in life (MIL). POS was defined as one's ability to assess him/herself and life circumstances and to feel positive about the future. After collecting data from 304 Polish participants between the ages of 19 to 45, Borawski found that participants expressed MIL when they possessed a positive perspective (POS) about being alone. Hemberg et al. (2021) echoed this idea in their observation about solitude being positive, constructive, and rejuvenating for those who intentionally seek it out and realize its benefits. French et al. (2022) argued this sense of POS is shaped by one's religious/faith views and practice.

Role of Normalization and Education

In addition to the above skills, normalization and education are also fundamental to combatting loneliness. For instance, in their study of individuals acting as caregivers to family members with dementia, Bjørge et al. (2019) learned that normalization and education were important components to the reduction of loneliness. Many of the caregivers in this study reported feeling lonely in their newfound role and disconnected from their ailing loved one; however, proper education helped to alleviate these feelings and allowed caregivers to connect with their loved one in more meaningful ways. Although Bjørge et al.'s study focused on dementia and not menopause, parallels can be drawn between the personal feelings and manifestation of grief, loss, frustration, sadness, loneliness, and transition in the life cycle.

Minkin (2019) built upon the importance of targeted education for practitioners and women alike in her educational article about menopause and its various side effects and possible treatments. She cited a previous survey of obstetrics and gynecology students that found formalized menopausal training in only 21% of their institutions and even less (16%) on-site training in a clinic designed to treat menopausal women. In other words, Minkin noted, many women are not receiving the validation and care they need for the unique symptoms they experience during the menopausal years because the practitioners treating them are not aware of the broad array of symptoms and do not assess these needs properly. The above-mentioned studies of Abedi et al. (2020), Arimoto and Tadaka (2021), Gadban and Goldner (2020), Luoma et al. (2019), Nelson et al. (2022), Pineros-Leano (2021), Ross et al. (2021), and Yazdkhasti et al. (2019) also demonstrate that cultural mores and expectations may further limit a woman's comfort level with confiding her struggles to a practitioner and unless that practitioner is

knowledgeable on this topic and able to offer empathy, the likelihood of identifying a woman's loneliness and depression, as related to the multifaceted changes of menopause, may be missed.

The author of this research study explored with participants the role of education and normalization to observe whether they, in addition to the above skills mentioned, also helped to reduce the detrimental effects of loneliness during the menopausal years.

Biblical Foundations of the Study

Despite the abundance of research and concern about loneliness and its connection to depression and anxiety, it seems there is still a lack of understanding as to a deeper spiritual need, which may be driving loneliness. For instance, if humans understood they are never truly alone because God is all present and sees human life on a continuum, perhaps the despair experienced when alone or during life transitions would be less problematic and hopeless. What if people could accept these inevitable periods of the lifespan with more grace and serenity, as some have been able to successfully do through the practice of wisdom and faith?

According to Arbuckle (2022), the Bible demonstrates the universality of loneliness and its associated feelings of abandonment and depression. For instance, David described the agony of being alone (*The Message,* 2002/2010, Psalm 22:1-2; 25:16) and Elijah felt abandoned by God and the Israelites and was even suicidal (*The Message,* 2002/2010, I Kings 19:19). The woman with the issue of blood also experienced social isolation for a prolonged period (12 years) and while it may not have been her choice to be isolated, the culture she lived in demanded it and she was aware of being an outsider as "She slipped in from behind and touched his robe" (*The Message,* 2002/2010, Mark 5:25-29). (It is important to note that the self-talk each of these individuals engaged in was critical in forming how they interpreted loneliness.)

Trevino et al. (2019) observed that social isolation is one phenomenon that increases an individual's spiritual and religious struggle. In fact, they noted that loneliness plays a significant role in how individuals cope with life stressors and their subsequent struggle with spiritual beliefs. This belief, they explained, is rooted in one's attachment style in that an individual's attachment to and sense of security in their relationship to God directly influences his/her perception of being abandoned and alone or supported and connected during stressful events. Trevino et al. arrived at these conclusions in their cross-sectional study of 2,115 U.S. adults, ages 18 or older. After being recruited through postal address lists provided by the United States Postal Service or by recruiters sent to areas with no postal service, inclusion criteria for participants were having experienced a stressful event within the previous 18 months and completing the measure used to assess religious and spiritual (R/S) struggle. This study focused on various components of the orienting system, which they defined as an individual's approach to stressful events. This system includes emotional, cognitive, spiritual, behavioral, and social components, according to Trevino et al., and can act as a protective factor against increased R/S struggle. However, results of this study showed no moderating effect of the cognitive, emotional, and spiritual components on a participant's ability to cope with stressful life events and subsequent R/S struggle. Social isolation, on the other hand, along with one's beliefs about the stressor (cognitive component), did act as moderators. In fact, there was a stronger relationship between stressful events and R/S struggle when participants reported having an insecure attachment to God and feeling isolated from others. As for the cognitive and emotional components, participants tended to experience greater distress when their perception was that they had experienced a steady stream of stressful events, which had a negative cumulative impact on their belief system and emotions.

The Bible demonstrates that loneliness is something Jesus also experienced and can relate to. Although he was surrounded by his disciples in the Garden of Gethsemane, for example, Jesus felt deserted by them prior to his arrest (*The Message*, 2002/2010, Mark 14:32-42). Following the death of his cousin John the Baptist, he also withdrew alone to pray and grieve (*The Message*, 2002/2010, Matthew 14:13). The first passage is an example of social and emotional loneliness, while the second represents an intention to seek out solitude to be alone and process. Jesus was fully God and Man, meaning he was able to experience the vast array of human emotion while living on earth. It is encouraging to know that he can relate to human sorrow, disappointment, betrayal, grief, and sadness, while also modeling healthy ways of coping with these experiences.

When it comes to designing psychological research, it is important to remember the element of hope that Jesus provides and not solely focus on the negative aspects of experiences like loneliness. While it is very real and overwhelming at times, loneliness does not have to leave people feeling despondent and isolated. Empirical research can assist practitioners with identifying effective interventions that not only alleviate symptoms of loneliness, but also help to change the narrative about its function and permanency.

Summary

The literature reviewed in this chapter demonstrates the various negative physical, emotional, cognitive, and spiritual side effects of loneliness, specifically during the menopausal years in women. As noted by Ozcan et al. (2022), the menopausal years represent a time of broadly significant changes in the lifespan, ones which are often exacerbated by the perception of becoming meaningless to others and socially isolated. Ozcan et al. observed that when a woman perceives that her role in the family, her femininity, attractiveness to her partner, or

ability to reinvent her life's purpose is irrevocably changed (and therefore lost), the likelihood of developing depression, anxiety, and a myriad of other side effects is substantial. The Bible also describes the profound pain that can result from feeling one's purpose in life and subsequent connection to others has been lost (*The Message*, 2002/2010, I Kings 19:19, Psalm 22:1-2; 25:16, Matthew 14:13, Mark 5:25-29; 14:32-42).

Despite these dreary acknowledgements of loneliness, both the Bible and psychological literature provide examples of people learning to cope and reframe their experience in positive ways. For instance, Lamentations instructs its readers to embrace the quiet because it is conducive to reflection and healing (*The Message,* 2002/2010, Lamentations 3:28-30). In addition, Brinthaupt (2019), Jenkins et al. (2022), and Thomas and Azmitia (2019) found that practicing faith, perspective taking, positive self-talk, and engaging in social connection help to reduce the negative effects of loneliness by acting as moderators on this experience. The present study expanded upon what is currently known about combatting loneliness by focusing on the lived experiences of women currently in the menopausal stage of life. By building upon the existing literature and learning directly from women through the mechanism of individual interviews, this study benefitted from the personal experiences and wisdom gained from women navigating menopause, which allowed the identification of themes and passing this information along to practitioners in the field.

CHAPTER 3: RESEARCH METHOD

Overview

The following chapter provides greater detail about the procedural methods of the present study. Beginning with defining the specific research questions regarding the experience of loneliness during menopause, an argument is made for a phenomenological approach, as well as justification for the suggested sample size through use of data saturation. In addition, inclusion and exclusion criteria are defined and a thorough description of participant recruitment, interview questions, observational protocols, maintenance of criterion validity, and researcher reflexivity is provided. Finally, this section describes the process of data analysis, to include the identification of specific themes, and a description of delimitations, assumptions, and limitations.

Research Questions

Research Questions

RQ1: How do menopausal women describe their experience with loneliness?

RQ2: How do menopausal women describe the factors related to reductions in loneliness during the menopausal years? For the present study, these factors have been identified as the practice of solitude, faith, perspective-taking, self-talk, and social connection.

Research Design

A phenomenological approach was used for this qualitative study, as it allowed the author to study the phenomenon of loneliness and collect data from multiple individuals (who were preselected by criteria defined in the study). Participants were individuals who have experienced loneliness during the menopausal years and have also been successful in identifying ways to overcome its negative side effects. Creswell and Poth (2018) explained this is a transcendental approach to phenomenology in that it focuses less on the researcher interpreting participants'

experiences and relies more upon the participants' interpretation and perception of their "lived experiences" (p. 76). Furthermore, this approach, as described by Creswell and Poth, summarizes the shared experience of a particular phenomenon (in this case, loneliness during menopause) and identifies the essence or themes of that experience. According to Lowe et al. (2021), this personalized approach to qualitative research is best when trying to understand an individual's inner world of loneliness. Ozcan et al. (2022) emphasized this point by recommending that research delve deeper into women's lived experience of menopause and loneliness, which is best facilitated through personal interviews. Although self-report quantitative studies may offer some insight into this experience, participants must respond to preselected criteria, which do not provide the range or nuance required for obtaining individualized experiences and insight.

Participants

Women of any racial, ethnic, cultural, religious, or socioeconomic background were invited to participate in this phenomenological study. The inclusion criteria were: Individuals who were female, between the ages of 40 to 60, had at least one child, were currently in perimenopause, menopause, or through menopause, and had experienced (or were currently experiencing) loneliness during this time. Participants were also required to have access to a computer and internet connection. Exclusion criteria included anyone who was currently suffering from detrimental mental health conditions that were untreated, including suicidality or active self-harm.

The ideal sample size for this study was ten to twelve women who fit the above criteria. In their research of how many individual interviews are required to reach saturation in a qualitative study, Guest et al. (2006) found that any more than 12 interviews start to become redundant. In fact, it was after conducting 12 interviews that variability in responses had reached

stability and no new codes or themes were identified. Guest et al. also cited previous research that found smaller sample sizes to be appropriate when participants share knowledge of a specific phenomenon, which was the aim of this present study. Guest et al. provided additional insight for reaching saturation with this suggested sample size by recommending that participants be interviewed separately to increase the likelihood of unique themes being presented and that the research questions, even if open-ended, are guided with a predetermined common experience of the phenomenon being studied. Without the presence of semi-structured questions, noted Guest et al., saturation cannot be reached.

This author conducted one individual interview with each participant and one group interview to learn about participants' lived experience of loneliness during the menopausal years. These interviews were conducted in a semi-structured format with the same open-ended questions posed to each participant. Additionally, Guest et al. (2006) observed that greater familiarity with a phenomenon, which in this case was loneliness during menopause, requires fewer participants to achieve saturation because each participant is an expert in the phenomenon being studied. Finally, Guest et al. found that there is a certain degree of homogeneity present in purposive sampling because participants are preselected per the inclusion criteria designed by the researcher(s). In other words, the likelihood of reaching data saturation with no more than 12 participants is higher because the similarities in lived experience of the phenomenon is also higher.

Using the criterion purposive sampling described above, participants for this study were recruited via an online survey posted on the Liberty University Doctoral Commons website. A notification explaining the study, its purpose, scope, and inclusion criteria were posted on the website, along with contact information for anyone who may have been interested (see Appendix

A). Those who expressed interest were asked to complete an on-line screening survey (see Appendix B). Upon receipt and determination of eligibility, participants were then asked to complete an on-line consent form, which outlined the details and participant criteria for this study (see Appendix D). Once the interviewer reviewed the surveys and selected candidates for the study, each participant was contacted by phone to confirm acceptance into the study. A follow-up email was sent to any candidates who expressed interest and met the inclusion criteria in the screening survey but did not respond to the confirmation of acceptance (see Appendix F).

Study Procedures

Individuals who responded to the recruitment notice were emailed a screening survey to determine their eligibility for the study, which included meeting the sampling criteria and being agreeable to the web-based interview process (see Appendix B). Once participants were determined to be eligible for the study, they were emailed a consent form (see Appendix D) and demographic survey (see Appendix E). Demographic information included age, race or ethnicity, cultural identification, number of children, age at onset of perimenopause or menopause, whether any complications had been (or currently were) being experienced because of the onset of menopause, and whether participants were currently being treated for any mental health condition(s) via medication or therapy. The interviewer then scheduled an individual interview with each participant which was conducted via a web-based communication format. The initial individual interview did not exceed 60 minutes in length. This interview focused on the two specific research questions and their specific components, beginning with asking participants to describe their experience of loneliness during the menopausal years and ending with questions about the factors identified in the above literature review regarding the reduction of loneliness during this life stage, i.e., solitude, faith, perspective-taking, self-talk, and social connection. The

interview itself was semi-structured with prepared questions serving as a guide and followed by more probing questions as the participants discussed their experience of loneliness. Each interview was audio recorded and the interviewer also took notes of her observations throughout the interview. Upon completion of the individual interviews, a second interview was also conducted with all participants simultaneously present via the same web-based format (not exceeding 60 minutes). The purpose of this second interview was to gain additional insights about participants' lived experience, as well as to give participants an opportunity to share advice for other women experiencing loneliness during the menopausal years. The interviewer also used this time to assess the need for any ongoing intervention among participants and to hear their reflections on the information-gathering process (see Appendix H).

The justification for two 60-minute interviews was based upon previous qualitative studies about the phenomenon of loneliness that also utilized in-person or web-based interviews to learn about participants' lived experience. For example, in their study of loneliness across a culturally diverse sample of men and women, Heu et al. (2020) conducted semi-structured interviews lasting 10 to 60 minutes in length per interview. Questions pertained to participants' perception of loneliness, coping strategies they may have employed, and potential protective factors against loneliness. Participants were also asked whether they had any suggestions to offer other people experiencing loneliness, in addition to completing a demographic questionnaire. Similarly, Hwang et al. (2019) conducted individual interviews with 16 older adults in a walking community exercise program regarding their experience of social isolation. These interviews lasted 30 minutes on average, were audio recorded, and then transcribed, as conducted in the present study. Although Lee et al. (2019) chose to conduct one individual interview lasting 28 to 58 minutes each with the mothers in their study who reported experiencing prenatal loneliness

and depression, they followed up by providing each participant with a debriefing information sheet that also included possible referral sources should they need it. This author elected to conduct a group interview to achieve this same purpose. Additional qualitative studies reviewed above conducted individual interviews ranging from 26 to 46 minutes (McKenna-Plumley et al., 2021), 30 minutes (Pineros-Leano et al., 2021), and 45 to 60 minutes (Ross et al., 2021). Each of these studies also asked participants to complete a demographic questionnaire and audio or video recorded interviews, followed by a detailed transcription of each. Interviews were conducted in a semi-structured format with open-ended questions designed to elicit personalized details about the experience of loneliness. This fits with Lowe et al.'s (2021) and Ozcan et al.'s (2022) recommendation that a study of this nature be individualized and focused on a woman's inner world of loneliness during the menopausal years.

Instrumentation and Measurement

The materials for this study included a web-based form of communication (Zoom was used for the present study), a computer to collect and store data, and emailed versions of the initial screening and demographic surveys (see Appendices B and E). The interviewer also utilized a phone to contact participants to confirm their acceptance into the study and schedule the initial interview.

Measures

The measures for the present study were designed to screen participants, as well as to assess any confounding or mediating influence of demographic factors. In addition, the measures discussed below provided a guided format for conducting interviews and debriefing the entire process with participants.

Consent Form

Individuals who responded to the recruitment notice were emailed a screening survey to determine their eligibility for the study (see Appendix B). This included meeting the inclusion criteria and being agreeable to the web-based interview process. Inclusion criteria for the present study were as follows: Individuals who were female, between the ages of 40 to 60, had at least one child, were currently in perimenopause, menopause, or through menopause, and had experienced (or were experiencing) loneliness during this time. Participants were also required to have access to a computer and internet connection. Exclusion criteria was anyone who was currently suffering from detrimental mental health conditions that were untreated, including suicidality or active self-harm.

Demographic Survey

The purpose of the demographic survey was to provide information about the participants' age, race or ethnicity, cultural background, number of children, age at onset of perimenopause or menopause, presence of complications due to menopause, and any mental health diagnoses or treatment at the time of the study (see Appendix E). Although this information was not utilized in a quantitative way, it shed light on any potential mediating or confounding factors on participants' lived experience of loneliness during menopause.

Individual Interview Questions

This study included semi-structured individual interviews with participants to gain understanding about the phenomenon of loneliness during the menopausal years. As discussed previously, Creswell and Poth (2018), Lowe et al. (2021), and Ozcan et al. (2022) recommended this approach because it allows for a deeper exploration into the personal lived experience of a

particular phenomenon. Open-ended questions were utilized to facilitate the interviews, followed up with more probing questions based upon participant responses (see Appendices G and I).

Group Interview Questions

Upon completion of the individual interviews, a web-based meeting with all participants was conducted for the interviewer and participants to share additional experiences or insights. The interviewer also used this time of debriefing with participants to assess any need for ongoing intervention (Appendix K) and to receive feedback about the data-gathering process (see Appendix H). This group meeting was hosted as a webinar via Zoom, which allowed participants to join with an invitation link while maintaining their anonymity.

Reliability and Validity

The validity of the above measurements was supported by the criterion specifically addressed in the guided and debriefing interview questions. Furthermore, the open-ended format of the interview process allowed for participants to describe their experience of the phenomenon being studied without the limitations of quantitative assessments with pre-determined questions and answers. The reliability of the present study was maintained by ensuring that all participants met the inclusion criteria and had personal experience with loneliness during the menopausal years. Additionally, reviewing the transcription of interviews and the author's notes taken during interviews allowed the author to record data in a streamlined fashion, after which recurring themes and statements were identified (see Appendix J). Finally, the author bracketed her

personal experiences and opinions from the experience, therefore allowing participants to describe and interpret their lived experience of loneliness during menopause.

Credibility, Transferability, Dependability, and Confirmability

This study followed Stahl and King's (2020) recommendation for maintaining credibility in a qualitative study by virtue of the author becoming very familiar with the phenomenon over the course of each interview and maintaining engagement with each participant. Additionally, the author continuously bracketed herself from the information shared and reflected on participants' comments and insights on a regular basis. As for transferability, Stahl and King recommended a "thick description" of the entire research process, including a thorough explanation of the phenomenon and population being studied, as well as a detailed description of the methods, measurements, analysis, and so forth (p. 27). Dependability was ensured through a twofold process of receiving direct feedback from the participants during the final debriefing interview regarding their experience of the research process and the author's interpretation of the information shared. Furthermore, receiving peer feedback following data analysis created accountability between participants' testimony of their lived experience and the author's own interpretation or bias. Finally, Stahl and King noted that confirmability is somewhat limited in qualitative research due to the limits of objective reality; however, objectivity was achieved by adhering to the standards designed in this study and relying upon participants' interpretation of their own reality.

Data Analysis

Interviews and transcription were conducted via Zoom, a web-based format that facilitates live telecommunications and recordings. Zoom also allowed for audio transcription to occur while the interview was being conducted and included a timestamp for easier reference to

certain portions of the interview later in the analysis process (Zoom Video Communications, 2023). Once interviews were completed, the interviewer read through the notes taken during interviews and listened to the recordings to organize the data into meaningful statements or direct quotes about participants' experience of loneliness. These statements were then compiled into themes to identify common experiences, perspectives, or coping mechanisms. Additionally, the interviewer followed Creswell and Poth's (2018) recommendation for developing a textural description of participants' experience, which described what they experienced, as well as a structural description, which focused on how they experienced the phenomenon being studied. Creswell and Poth explained that organizing participants' statements and descriptions in this fashion is the best way to accurately capture the participants' lived experience. Finally, the textural and structural descriptions were combined to communicate an overall essence of the data collected.

Delimitations, Assumptions, and Limitations

The delimitations of this study were defined by the inclusion criteria and the decision to study how a specific segment of the population, in this case menopausal women between the ages of 40 and 60, experienced and coped with loneliness. It was recognized in the literature review above that this population experiences loneliness in unique ways due to the convergence of physical transformations because of menopause and additional changes as a result of launching children and other familial transitions typified in this life stage. The author assumed that participants described their experience of the menopausal years and loneliness accurately, which was facilitated by the open-ended interview style of this study. In this type of phenomenological qualitative study, participants are assumed to possess the knowledge to answer the author's questions and to be experts in their own experience.

Some of the challenges anticipated with this study had to do with the format intended to collect data, which was through individual and group interviews. This type of data collection is inherently time consuming and requires extremely thorough note taking, correctly working recording devices or technology, and a very careful review of the information gathered in order to accurately represent the participants' lived experiences and categorize them into themes. Retention may have also been an issue during the time elapsed between individual and group interviews, although the author scheduled these interviews relatively close together and asked participants to agree to both interviews upon providing consent. Having said that, participants were informed that they could discontinue participation in the study at any time for any reason without fear of retribution.

Another potential challenge had to do with the author's own bias getting in the way in the form of judgments or preconceived ideas. This is why it was essential that the author practice self-awareness and bracket herself from the information shared, as much as possible. It was also important for the author to suspend judgment or personal beliefs regarding loneliness, its clinical side effects, and best practices for resolving loneliness so that participants could shed light on the coping mechanisms that worked best for them. Limitations to this study may have to do with the generalizability of participants to a larger menopausal population, especially across culture. Although menopause and loneliness are joint phenomena reported across culture and demographics (Kaur & Kaur, 2021; Ozcan et al., 2022; & Yazdkhasti et al., 2019), those who chose to respond to the recruitment notice may have been more inclined to participate in research studies, had some vested interest, or may have only represented a certain segment of women. Finally, it was possible that participants' recollection of events may have been distorted by time and loss of memory.

Reflexivity

The interviewer was a female developmental psychology doctoral student with a master's degree in counseling and a bachelor's degree in Spanish and international studies. There was no prior relationship or interaction between the interviewer and the participants. Throughout the interview process, the interviewer practiced self-awareness and bracketed herself from the information shared, as much as possible, in order to gain new perspectives and learn from the participants' experiences and inherent wisdom regarding their familiarity with loneliness. The interviewer also suspended judgment and personal beliefs regarding loneliness, its clinical side effects, and best practices for resolving loneliness so that participants could shed light on the coping mechanisms that worked best for them. This was deemed important because the goal of this study was to enable mental health clinicians to teach their clients effective and personalized skills of overcoming the negative mental and emotional side effects of loneliness.

Summary

The methods outlined in this chapter were guided by the present study's research questions regarding loneliness during the menopausal years. As such, a phenomenological study was designed that utilized a series of individual and group interviews aimed at better understanding participants' personal and lived experience of loneliness during menopause. Through the process of analyzing responses and identifying themes, the author was able to create a textural and structural description of the data, which could then be used to communicate an overall essence of this phenomenon.

Validity in the present study was maintained by adhering to the criterion specifically addressed in the guided and debriefing interview questions. Likewise, reliability was retained by ensuring that all participants met the inclusion criteria and had personal experience with

loneliness during the menopausal years. The author bracketed herself throughout the research process and also relied upon feedback from participants during the debriefing interview, as well as peer review of the data gathered, to ensure the credibility and dependability of this study. Any limitations due to a lack of generalizability to outside populations were taken into consideration and addressed in the results portion of this study.

CHAPTER 4: RESULTS

Overview

The purpose of this qualitative phenomenological study was to explore the lived experience of loneliness in menopausal women. Furthermore, factors related to reducing loneliness in this life stage were examined. Women of any racial, ethnic, cultural, religious, or socioeconomic background were invited to participate in this phenomenological study. The inclusion criteria were: Individuals who were female, between the ages of 40 to 60, had at least one child, were currently in perimenopause, menopause, or through menopause, and had experienced (or were currently experiencing) loneliness during this time. Participants were also required to have access to a computer and internet connection. Exclusion criteria included anyone who was currently suffering from detrimental mental health conditions that were untreated, including suicidality or active self-harm. Women who met the inclusion criteria and completed the screening survey then completed a brief demographic survey and participated in a 60-minute individual interview, as well as a 60-minute group interview. The following research questions acted as a guide for this interview process:

RQ1: How do menopausal women describe their experience with loneliness?

RQ2: How do menopausal women describe the factors related to reductions in loneliness during the menopausal years? For the present study, these factors were identified as the practice of solitude, faith, perspective-taking, self-talk, and social connection.

Upon completion of the interviews, the interviewer read through the notes taken during interviews and listened to the recordings to organize the data into meaningful statements or direct quotes about participants' experience of loneliness. These statements were then compiled into themes to identify common experiences, perspectives, or coping mechanisms. These results are

described in the following sections, including demographic information, descriptive results, and overall relevant themes related to the experience of loneliness during the menopausal years. In order to protect their confidentiality, pseudonyms were assigned to each participant.

Descriptive Results and Demographics

Ten women participated in this study, ranging in age from 44 to 60. Seven women identified as White and three as African American. Five of these women were married at the time of the study, four were divorced, and one was engaged. The number of children that each participant had ranged from one to seven, eight of whom had been launched from the home at the time of this study. The average age of onset of perimenopausal symptoms was 45.4 years, with the youngest age of onset at 37 and the oldest at 55. Two women reported that they were in the perimenopausal stage at the time of this study and the remaining eight had completed menopause, although many still experienced various symptoms related to menopause. Of the ten women interviewed, all reported that they intentionally sought times of solitude as a coping skill, to be discussed in greater detail below.

Study Findings

The shortest individual interview was 45 minutes long and the longest was 83 minutes. Only three participants were able to join the group interview, which lasted for 45 minutes. Once interviews were completed, the interviewer read through the notes taken during interviews and listened to the recordings to organize the data into meaningful statements or direct quotes about participants' experience of menopause and loneliness. These statements were then compiled into themes to identify common experiences, perspectives, or coping mechanisms. Finally, the author combined the textural descriptions (*what* participants experienced) and the structural descriptions

(*how* participants experienced it) to communicate an overall essence of the data collected. Relevant statements and themes are organized by each research question below.

RQ1: How do Menopausal Women Describe Their Experience with Loneliness?

Physical Symptoms

A wide variety of physical symptoms were described by the participants in this study, which, in many cases, began before women recognized they were in the perimenopausal stage and endured well past they were medically declared to be post-menopausal (see Figure 1). These symptoms included vasomotor effects, such as excessive sweating, hot flashes, and night sweats. Heather described feeling a "constant internal burning" and Sally shared that the extensiveness and intensity of her hot flashes led to a feeling of "desperation." Thinning of hair, loss of hair, and the growth of hair in "strange places," such as on the face, were also reported. A variety of gastrointestinal issues were commonly reported and included gastritis, nausea, bloating, frequent urination, and bowl problems. Sleep problems, such as a disruption in the sleep/wake cycle, were reported, as was extreme fatigue.

Every participant lamented weight gain during the menopausal years, particularly around the stomach and hips, and the difficulty in losing this weight as opposed to their earlier years. Even those women who described themselves as having been physically fit and regularly exercising throughout their lives struggled with weight gain and loss of strength and motivation to exercise. Evelyn had a blood issue that depleted her hormones. All of the women experienced significant decreases in their estrogen and testosterone levels, one woman continued to experience intermittent periods, and three continued to experience symptoms related to menstruation even after they were no longer getting a regular period each month. In fact, Teresa,

who was post-menopausal, explained that her emotions tended to match the menstrual cycle of her two teenage daughters who were still living at home.

Other physical changes related to fluctuations in hormones were described, as well. These included an increase in facial acne, thinning of hair and nails, unusual food cravings, endometriosis, and adenomyosis. Vaginal dryness, discomfort during intercourse, and a decrease in libido were also commonly reported. Six of the ten women were either married or engaged at the time of this study and all six expressed distress about the sexual changes they had experienced, stating they were worried about how this would affect (or had affected) their marriage or romantic relationship. The decrease in sexual desire, along with pain or discomfort during sex, and weight gain that caused women to feel unattractive, represented shifts in romantic relationships and lower self-esteem for many women. Even those women who described their husbands or partners as supportive were aware the men in their lives could not relate to their experience and women were often at a loss for how to vocalize the many changes occurring inside. Carrie shared that her husband had always viewed her as "tough," which made it difficult for him to understand her emotional experience during menopause. Evelyn, whose husband had cancer and had lost sexual function as a result, found it challenging to disclose her emotions and sense of isolation during this time. She explained that she wanted to remain positive for her husband, yet felt lonely because she was not able to be intimate with him and lacked the words to describe her experience. In addition, she launched two children during this time and lacked support from other women and practitioners to help her recognize (and validate) the changes that were occurring in her body. Overall, the women expressed a specific loneliness that was related to their decreased libido and inability to connect sexually with partners with the same ease or comfort level they had previously known.

Three of the women interviewed had undergone a hysterectomy, two of whom retained at least one ovary, meaning they were not forced into early medically-induced menopause. Carrie had breast cancer and a brain tumor around the time of menopause, therefore complicating her physical symptoms and sometimes making it difficult for her to know the exact cause of what she was feeling. All of her life, she had received positive attention for her red curly hair, but after losing her hair due to chemotherapy, it grew back in much different and took some getting used to. Carrie's loneliness was directly related to feeling "old and insignificant," as if people were looking "past" her, treating her like an "old lady," once her hair and body changed. Katie described a family trauma, including the loss of her husband, that took place around the time of menopause. These traumatic events made it difficult for her to be fully aware of the physical and emotional changes occurring in her body during that time. Nevertheless, she believed the trauma induced an early menopause, which she completed by the age of 44.

A persistent theme among participants was the lack of motivation to exercise that came along with menopause and the associated fatigue and weight gain due to hormonal changes. While many women used to be strong and athletic, running marathons or lifting heavy weights, for example, menopause depleted much of this strength and they had to work harder to maintain physical wellness at this stage of life. Patty described a similar experience and suffered loss of bone mass, as a result. Evelyn shared that she preferred to sleep instead of exercise and experienced fatigue, weight gain, and intermittent periods, which, in turn, also affected her motivation to exercise. Her experience was similar to Carrie's in that she worried her physical changes may affect her work identity and people would deem her as "obsolete." Heather reported that she had undiagnosed celiac disease for 28 years, which created a pattern of ignoring her body and its various discomforts because she did not know what was causing them. This trend

continued into her menopausal years, but eventually she obtained an accurate diagnosis and began learning mind-body awareness, as well as self-compassion toward her physical self. Additional medical conditions reported during the menopausal years included diabetes, cancer, anemia due to excessive bleeding during menstruation, gastric sleeve surgery, miscarriage, still birth, frozen shoulder, and joint pain.

Figure 1

Physical Symptoms Word Cloud

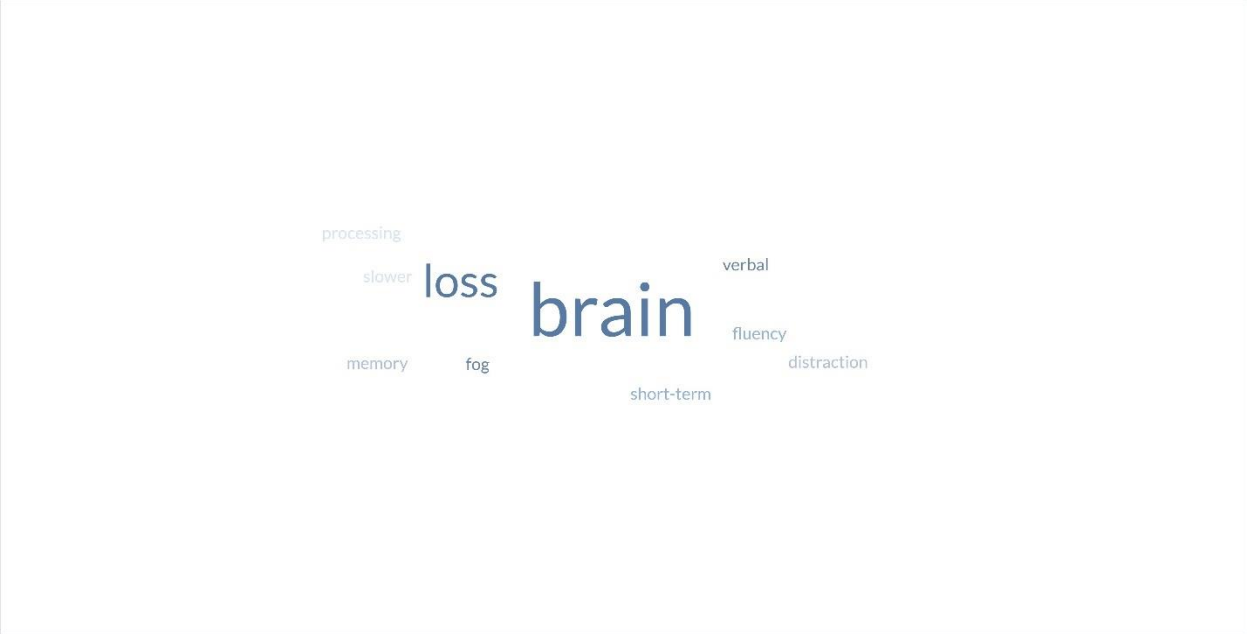
Cognitive Symptoms

In addition to the physical symptoms described above, the decrease in estrogen and testosterone also coincided with various cognitive symptoms for women (see Figure 2). Four of the women noted a shift in their thoughts and emotions during this time. Cognitive symptoms included “brain fog,” loss of verbal fluency, short-term memory loss, distraction, and slower processing speed. Taylor, who also had ADHD, found it much more difficult to find words and easily lost her train of thought, which she described as frustrating. Carrie confided that people

tended to view her as strong, which made her wary of confiding in others about her experience because she did not want to "shatter" their image of her or feel invalidated for her struggles. All of the women shared that they played brain games or actively learned new things, including the pursuit of an additional degree, to keep their brains challenged and engaged. Three women also took a brain supplement to help with memory loss and brain fog.

Figure 2

Cognitive Symptoms Word Cloud



Emotional Symptoms

The emotional symptoms experienced by participants in this study were directly related to the physical and cognitive symptoms described above (see Figure 3). Each participant talked about a shift in their emotional state that occurred after perimenopause began and which reflected the various unexpected changes and hormonal fluctuations that ensued. These symptoms included depression, anxiety, low self-esteem, discouragement, anger, irritability, sadness, self-consciousness, desperation, loneliness, guilt, grief, confusion, and rage. The way in

which these emotions were expressed included decreased emotional regulation, mood swings, lashing out, “stress cursing,” negative self-talk, rumination on past events or “lost opportunities,” isolation, and reflection on life accomplishments. Two women also experienced suicidal thoughts during this time.

Specifically, the discouragement was related to not receiving proper validation, education, and treatment for menopausal symptoms. This also lent itself to confusion, as women often questioned their own experience or sought explanations that remained unanswered. The grief was associated with no longer being able to have children, which for some came naturally and for others was forced by medically necessary hysterectomies. Three of the women reflected that although they no longer intended to have children or were content with their existing families, the idea of being fertile was still a significant part of their identity. After completing menopause, for instance, Evelyn initially felt excited not to have a period anymore, but when the full reality of this change set it, she felt she lost something. Due to fluctuating hormones, Serena had to wean her youngest child before either of them was ready to do so. After experiencing the still birth of her child, Heather had to have a hysterectomy, the finality of which made grieving the loss of her child even more difficult. Going through menopause and losing the ability to procreate created sadness and grief for these women, especially as they sought to redefine their role in life and how they would derive meaning as mothers of children who were grown and no longer dependent upon their care.

The desperation these women expressed was related to persistent vasomotor symptoms and their lack of remediation. Low self-esteem and self-consciousness were a direct result of weight gain and decreased libido, which at some point caused all the women to feel disdain toward their physical bodies and concern about how this would affect their romantic

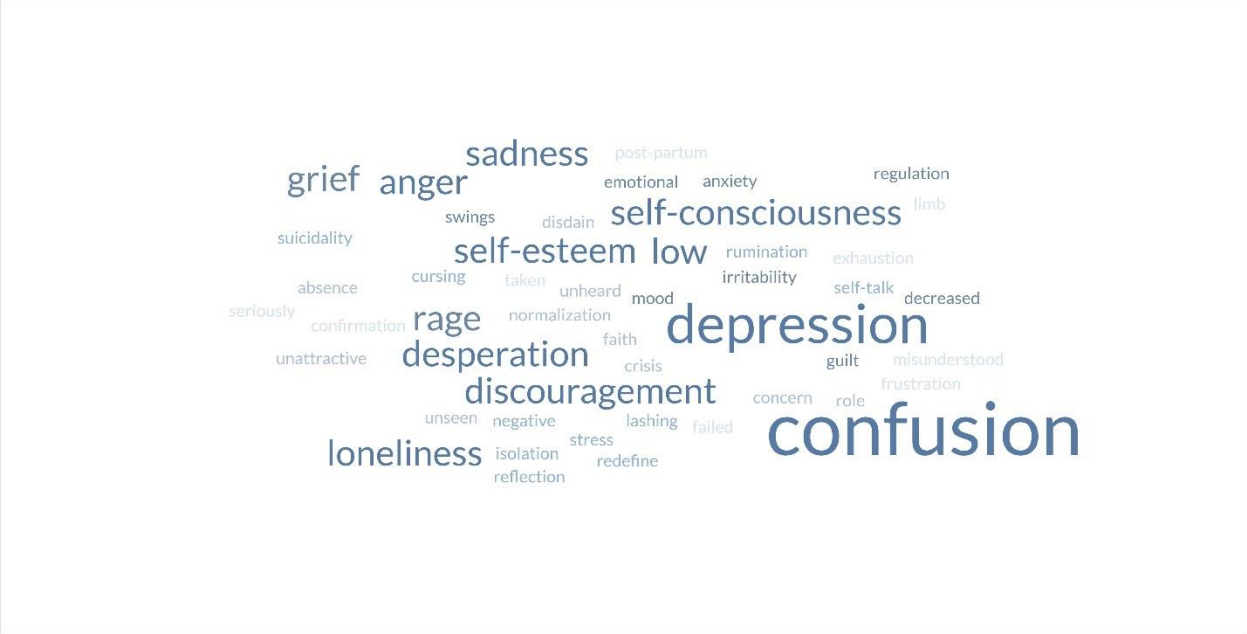
relationships. Sally confided that looking in the mirror emphasized the physical changes she had experienced and all women admitted to feeling unattractive because of weight gain, hair loss, skin changes, and so forth, for at least part of their menopausal experience. Serena and Katie experienced a crisis of faith during the menopausal years, questioning God's design and purpose for having women suffer, which sometimes resulted in anger and rage.

A dominant theme among all the women interviewed was feeling unheard and unseen during this time, a feeling that was exacerbated by not having adequate information about menopause, its symptoms, and possible treatments. Two women reported going through menopause either before or after the majority of their peers, which created an absence in much needed normalization and confirmation of symptoms. Another common theme was the confusion and frustration that accompanied not understanding what was happening to their bodies or not receiving proper treatment. Sally, for example, felt she had been "failed" by the medical community, especially by her gynecologist, who misunderstood the source of her depression. Her doctors urged her to take a variety of medication to alleviate her symptoms, but did not validate what she was going through nor did they normalize it as typical of the menopausal process. Instead, Sally described feeling she was "out on a limb" trying to navigate this life stage and her body's changes on her own. Teresa's experience with the medical community resonated strongly with that of Sally. She did not feel taken seriously by her doctor, which caused her to be less inclined to advocate for herself because she felt she would not be heard or that her symptoms would not be deemed "worthy of investigating." She described the loneliness and exhaustion of walking this journey alone, as well as the confusion of not understanding what was happening to her body or knowing how to access the care she needed. Zoe had a prior history of post-partum depression, which may have predisposed her to depression during the menopausal

years. She was taking an anti-depressant at the time of this study to help manage these symptoms. Patty also admitted to feeling depressed at times during the menopausal years, especially when she felt lonely and missed her son who had launched from the home or her parents who both passed away during this time. Sally reflected that it was more difficult for her to maintain an "upbeat mood" because of the "up and down" affect her hormones had on her emotions.

Figure 3

Emotional Symptoms Word Cloud



Loneliness

For the women in this study, loneliness was the biproduct of having an empty nest, misinformation about menopause, lack of validation and normalization, inappropriate treatment, and an inability to vocalize their experience. For those women who had already launched a child(ren) from the home, there was sometimes an uncertainty about what the future would hold and a loneliness that settled in around the quiet and changing routines. As she thought about

aging, Zoe stated that loneliness often felt like it would last forever. Evelyn said she could not talk about her experience with her husband because she did not want to be perceived as negative and was at a loss for words to describe how she felt. This led to her feeling increasingly lonely in her marriage. One woman wondered if her menopausal symptoms were somehow her fault, which led to a verbal and emotional withdrawal from her spouse and loved ones, also resulting in profound loneliness. Taylor attributed her loneliness to feeling everyone else had moved on with their lives, while she felt left behind and forgotten. Due to relocations that occurred during this life stage, two women dearly missed girlfriends with whom they could talk and share their experience with, which also added to their sense of being alone and contributed to feelings of loneliness.

The women interviewed in this study expressed varying degrees of awareness about their loneliness and the need for a renewed perspective to help alleviate the side effects of this phenomenon. After her son moved out, for example, Patty, who was a single mom, chose to embrace her alone time as an opportunity to engage in "single activities." She started doing "Patty's Day Out" on a regular basis, choosing to reframe this stage of life as a time to focus on herself and pursue individual interests instead of viewing it solely as a time of loss and loneliness.

RQ2: How do Menopausal Women Describe the Factors Related to Reductions in Loneliness During the Menopausal Years?

As discussed in the literature review above, multiple practices or coping skills have been identified as fundamental to the mitigation of loneliness across all populations, stages of life, and circumstances. Since the present study identified the practices of solitude, faith, perspective-

taking, self-talk, and social connection as significant to the reduction of loneliness during the menopausal years, participant responses have been organized according to those factors.

Solitude

Each of the participants in this study described feeling lonely at various times throughout the menopausal life stage. As discussed above, this was often a result of feeling isolated in their experience and lacking support from friends, family, and medical practitioners. It was also a result of various changes occurring during this life stage, such as the launching of children. Despite the sadness, depression, anxiety, and frustration that came with loneliness, each of the women shared that they intentionally sought solitude as a way of coping through this time. Just as Thomas (2023) and Thomas and Azmitia (2019) explained that solitude can be a healthy practice when not unwanted or prolonged, the women in this study understood the merits of embracing times of quiet to reflect, pray, practice mindfulness, and reframe their perspective. In fact, each of the women developed their own solitude practices to cope with and reframe their experience of loneliness.

Sally explained that in times of stress, she sought alone time to be quiet and present in nature. She used this time to connect with God and to identify solutions to the problems she was facing. Carrie also enjoyed being by herself, which allowed her to focus on her relationship with God and decompress from work. She explained that her job took a lot out of her in order to be fully engaged, which made seeking solitude essential. Carrie viewed her home as a retreat and allowed the solitude to renew her. Like Carrie, Teresa always had to be “on” for her job and as a mother of teenagers, thus being quiet was key for her to refresh and communicate with God. She accessed these times of quiet by sitting in her yard, taking a hot shower, or going for walks.

Evelyn also liked to enjoy a cup of coffee outside in her yard while alone. This gave her brain a break and gave her the space to enjoy the quiet without having to focus on anything in particular.

Taylor described herself as a "loner" who preferred to be alone. Her reasons for embracing solitude were somewhat different, however, in that she did not want to be surrounded by "drama." Solitude allowed her to feel peaceful and to hear from God about areas in her life that needed growth or change. She explained that solitude allowed her to maintain the character she desired to have and helped her to avoid expressing a temper. Whenever she felt lonely, Taylor reminded herself that at least she was not "stuck" in "foolishness or drama" or a bad relationship.

Serena also craved solitude, explaining that as a mom she required times of "sensory deprivation." She went for walks with her dog, ran or went to the gym, and took a hot bath every night, during which time she read or scrolled on her phone. Heather also took regular baths in her jacuzzi tub or swam laps at a local pool, referring to this practice as her "mermaid time." As an introvert, she needed times of quiet to be alone and rest and noted that when she was not able to engage in these practices, her mental health was negatively impacted. Like Carrie and Teresa whose careers required a high level of emotional engagement, Zoe needed times of solitude to cope with the demands of being a social worker. She described feeling refreshed when she separated herself from the "pack." Without this time to "disassociate" from people and other people's emotions, Zoe noticed that she felt lonely or unable to be fully present with her son. Although she enjoyed being with people and entertaining, Patty also liked her alone time. She found the quiet and stillness to be therapeutic, embracing the time to do what she wanted to do. Katie acknowledged that she had become more comfortable with solitude with age. Although she did not necessarily want the quiet and solitude that functioned as a trauma response for her, she

also became used to it. She reflected that there was no way of knowing what another person's experience was and found it very difficult to communicate her own experience, which led to an increasing sense of isolation for her.

An overwhelming theme to the practice of solitude for each of the participants in this study was that without it, the practices of faith, perspective-taking, and self-talk were non-existent. In other words, it was understanding the benefits of solitude and how it created a space for reflection that allowed women to focus on these additional coping skills. Furthermore, it was important that times of solitude were a frequent occurrence so that these positive coping skills could be maintained. As evidenced in this section, each of the women developed their own unique approach to engaging in times of solitude according to their personal needs and interests.

Faith

Although it was not a required criterion for this study, each of the participants interviewed claimed to have a personal relationship with God that was exercised through daily faith practice, including prayer, Bible reading, devotionals, and corporate worship. While many women attended church services, volunteered at church, or participated in church-organized activities, their primary development of faith took place within times of solitude. Two of the ten women described experiencing a crisis of faith during which time they questioned God's goodness and his design for women. This resulted from tremendous physical and emotional struggle during the menopausal years, including multiple traumas for both women and their families. For Serena, resolving her anger toward God involved reminding herself that she was never truly alone with God and that he had purpose for her life. Additionally, when she felt lonely in her marriage, she reminded herself that her marriage was a "spiritual covenant" and that her husband was not trying to make her feel lonely. This reminder motivated Serena to do

whatever she could to improve her marriage instead of further isolating or telling herself that God and her husband did not care. Katie, on the other hand, admitted that she still was not sure where she stood in regards to her faith, noting that she and her son had experienced very little healing or improvement despite her persistent prayers.

Evelyn shared that her husband did not attend church with her, so she often sat alone during church services and lacked appropriate support from age-appropriate women's groups. However, she decided to make a point of trying something new or volunteering in her church each month as a way of connecting with other people. Despite feeling alone at church at times, Evelyn stated that attending services helped her to feel closer to God, thereby reducing the overall loneliness she felt. Remembering she was never truly alone because of her relationship with God helped Patty to address her loneliness. She explained that she had to learn to trust God's timing and used her time of solitude to allow God to reveal things she could work on in her life. Heather reminded herself that Jesus also went through times of being alone and was encouraged that He was with her whenever she read the Bible. Similarly, Taylor utilized her "prayer closet" to pray and read the Bible, which helped her to remember God had a plan for her life. This typically helped her to feel better and to move on from the loneliness she was feeling. In addition, Taylor noticed that as she became more adept at recognizing her negative self-talk about being alone, she was quicker to address those thoughts with prayer and Bible verses. She noticed a significant difference in how this practice "freed" her up sooner from her negative self-talk and reduced the frequency of this chatter.

Not only did spiritual practice reenergize Teresa, but being connected to other "spiritually aware" people also reduced her feelings of sadness. On good days, she was able to practice positive self-talk such as "You have purpose, God is faithful and has a plan, stay listening." On

bad days, however, her self-talk took on a more negative tone. However, recalling scripture verses and remembering how she wanted to behave as a mom helped her to "snap out of" this mentality quickly. Carrie also emphasized the importance of knowing the truth about herself and her situation, which she found through prayer and Bible reading. Whenever she felt old or lonely, these practices enabled her to reframe her experience. She spoke Bible verses out loud to herself, told the intrusive thoughts to stop, affirmed herself, and utilized a sense of humor to address her loneliness. Like many of the other women, Sally's relationship with God allowed her to remember that her life had purpose and she was not alone. She also recognized that other women were going through the same experience, which helped her to avoid self-pity. Zoe utilized prayer and spirituality, as well, to help her take perspective and remind her of life's temporality. She held an "existential" view of humanity, which allowed her to see something more special and bigger than her experience. She found purpose in her loneliness, primarily as a time to develop her character. By recognizing and practicing "agency," she was able to do something about her loneliness when she chose to.

Perspective Taking

As mentioned previously, perspective-taking for the women in this study was a skill developed through the practices of solitude and faith. It was in these quieter times of contemplation and reflection that women were able to adjust their perspective of the menopausal life stage and the loneliness that accompanied it. Changing one's perspective involved recognizing they were not alone, that God was with them, that other women were going through a similar experience, and that their lives held purpose. The concept of purpose was one repeated by every participant and functioned as a positive reframe for the overwhelm of emotions and loneliness the women often experienced. Practicing gratitude and remembering their life stage

was temporary were also helpful perspective shifts. Instead of engaging in negative self-talk and calling herself a "dork," Heather tried to be positive. She and her husband also started using a daily communication tool to help them better communicate their feelings to one another. When she was feeling lonely or experiencing fluctuating emotions due to hormonal changes, Evelyn asked herself what would bring her "joy." She also counteracted negative thoughts about herself, such as feeling unattractive due to weight gain, with statements of affirmation.

Self-Talk

Self-talk was related to perspective-taking in that if negative, it led to reevaluation of one's perspective and a shift to healthier and more affirming self-talk. Negative self-talk often centered around the physical changes experienced during menopause, as well as the loneliness participants felt during this life stage. Katie explained that her loneliness and subsequent negative self-talk were partially a result of not being able to tell her own side of the story regarding her family's trauma. She sometimes questioned whether she allowed the trauma to occur or if it was a result of not being worthy of love. She started writing a book about her experience to process what occurred and to give a voice to her family's story.

Instead of telling herself she was unattractive, Evelyn reminded herself she had not exercised recently and identified methods of self-care to improve her self-image. Similarly, Patty sometimes wondered if her boyfriend would still be interested in or attracted to her because of her decreased libido and weight gain. She learned to talk gently to herself and to be patient with the process as a means of overcoming this negative self-talk and doubt. Instead of isolating in their narratives about being alone, Heather and Taylor reminded themselves they could reach out to someone if they chose to. When she was lonely, Taylor sometimes questioned whether people had forgotten about her, but then she reminded herself they had lives too and that it was not "all

about [her]'." Sally sometimes missed her more athletic body when she looked in the mirror and instead of focusing on the negative, she decided to engage in self-care and asked herself what she could do about her weight or body image. Additional tools utilized by these women to alter their self-talk included praying, reading the Bible to remind themselves of God's perspective, asking for guidance, distracting themselves, recognizing their accomplishments, and practicing gratitude.

Social Connection

Although each of the women in this study reported feeling isolated in their experience of menopause at times, they also testified to the importance of social connection. Because all the participants felt unprepared for and uneducated about the physical, emotional, and cognitive changes that occurred in their bodies, talking to other women about their shared experience served to answer questions, relieve fears, and assuage guilt about having lost motivation or gaining weight. Zoe described the act of connecting socially as the "antidote" to being lonely. This resonated with Sally who found that as she talked more about her experience, other women were inclined to open up about theirs. She tried to be "authentically present" with people, which for Sally meant that she actively listened and heard what they had to say. As a result, she reported feeling much more connected and less lonely. It also helped her to get out of the house and her self-imposed isolation by connecting with girl groups that "[got] it." Heather also gathered with a group of girlfriends on a regular basis to talk about their mutual experience of menopause and the loss of her son, which she called the "loss of what should be." She also posted requests for prayer on Facebook as a way of gaining support and connecting with others. Serena and Patty maintained connection with their military friends who were able to empathize with their experiences in a unique way. Specifically, Patty shared that as a veteran, she

participated in a military sorority, through which she felt connected and less alone. Attending church also provided important social connection for both of these women.

While seven women actively sought social connection, three lacked it or chose to limit it. For example, Teresa described herself as an "ambivert" and explained that while socializing helped to "fill her up," too much of it could be draining. In other words, she had to be aware of becoming overstimulated with social connection. When in balance, however, Teresa stated that interacting with others socially allowed her to feel encouraged and capable of doing anything. Like Teresa, Serena also benefitted from social connection, stating it filled her "cup" and felt good. However, at the time of this study, her family had relocated to a smaller town where she was far away from familiar friends and family and she was also pursuing a PhD, all of which resulted in less socialization. Despite these changes, Serena made it a priority to volunteer at church to meet new people and joined a PE class at a local community college, as well. These activities helped her to feel she was part of a group and not alone. Carrie expressed awareness about her need for more social connection, but explained that her job required long days, which did not leave a lot of time for socializing. She preferred to spend her free time with family, adding that she did not know very many females to talk to.

Finally, Taylor, Katie, and Evelyn reported a lack in social connection and missed the support this could have offered. Evelyn stated that she had female friends, but they did not make time for each other. As a result, she had not talked to anyone about her experience of menopause. Following a relocation and the closure of her church, Katie also lacked friends to talk to about her experiences with menopause and family trauma. She talked to her parents on the phone and occasionally reached out to friends from college. Taylor admitted that she did not seek socialization with her friends very often and had made it a point not to isolate so much at the

time of this study. She set a goal of getting together more often with female friends and went out with some other women from church. In addition, Taylor participated in a group text with other women in which they talked about menopause and validated one another.

Other Coping Skills: Medical Treatments, Diet, Exercise, Validation, and Normalization

Sally's approach to coping with the emotional ups and downs of menopause was to "suck it up." She described feeling frustrated because there seemed to be "no solution" for the symptoms she was experiencing and it took more effort to achieve and maintain an "upbeat mood." Hormonal supplements did not work for Sally, although she later started taking a natural supplement that yielded some positive results.

Of the ten women interviewed for this study, six sought medical treatment at some time during menopause to help remediate the physical, cognitive, and emotional symptoms they experienced. This treatment included a variety of hormonal supplements, as well as natural supplements, such as Estroven. One of these women reported no improvement with treatment, while the remaining five testified a reduction in negative symptoms, such as anxiety or weight gain, as well as an increase in energy, focus, and motivation. Several women also incorporated regular exercise and/or weight training and monitored their diet in order to avoid foods that exacerbated weight gain and other symptoms. Physical exercise was also cited as a positive outlet for the wide range of emotions experienced during this time.

Each of the women emphasized the importance of opening conversations about menopause and loneliness, noting it is a topic lacking in depth and accurate information. Instead of remaining quiet about their experience and isolating, they urged women to talk to their friends, mothers, sisters, daughters, and co-workers about their symptoms and related emotions. Each of these women shared stories of how doing so helped them to feel less alone and they

expressed gratitude for this study, stating that the topic of loneliness during menopause needs to be researched and discussed further so that women can receive the normalization and validation they need.

Summary

A variety of physical, cognitive, and emotional symptoms were commonly experienced among participants throughout the menopausal years. These included, but were not limited to, vasomotor symptoms, fatigue, weight gain, decreased libido, foggy brain, anxiety, frustration, anger, isolation, and loneliness. The women in this study also talked about their disillusionment with the medical community who often minimized or overlooked the source of their symptoms or did not help them access appropriate treatment. In addition, every participant described feeling alone in her experience at some point during menopause, if not during the entire process. This was most often attributed to a lack of education and awareness about what was going on in their bodies, lack of spousal support and validation from doctors, and a lack of normalization from other women who were going through (or had gone through) menopause.

As discussed in the literature review in chapter two, menopause often coincides with significant life events and transitions that are germane to this stage of life. This proved to be true for the participants in this study, as well. For example, several participants relocated or launched children to college, professions, or marriage during this time. Two women also became grandmothers. In addition, they experienced significant changes in their careers or relationships. For instance, one woman lost her husband during this time, four others went through a divorce, and one lost both of her parents. All ten of the women interviewed were either in the middle of pursuing a PhD or had recently completed their doctoral program, with hopes of changing careers or expanding their current expertise. Serena’s husband was assigned a new station in the

military during this life stage, which meant the entire family had to relocate to a smaller town far away from friends and family. Her husband also deployed during the COVID-19 pandemic after she had taken a full-time job, making it extremely challenging to care for their five children without support nearby. As mentioned previously, several women also went through significant physical changes, including hysterectomies, miscarriages, still birth, and cancer, which altered their ability to have more biological children even though not all had planned on being done with child bearing at the time these medical issues occurred.

As a result of these changes and experiences, all participants experienced loneliness and developed coping skills to address it. These skills ranged from seeking solitude and times of quiet to socializing with other women in their cohort who could relate to their experience and validate the myriad of symptoms experienced. In the chapter that follows, these coping skills are discussed in further detail, along with suggestions as to how they may be applied to the fields of medicine and counseling for the improvement of intervention and treatment. A discussion of limitations and recommendations for additional research is also provided.

CHAPTER 5: DISCUSSION

Overview

The purpose of this qualitative study was to explore the phenomenon of loneliness and related coping skills during the menopausal years, as defined by the lived experience of participants involved. As discussed previously, the specific coping skills of practicing solitude, faith, perspective-taking, self-talk, and social connection were explored, as were additional skills identified by participants, including hormonal replacement, diet and exercise, and mindfulness.

The following sections summarize these findings and discuss their implications and meaning for this topic, as well as for the broader fields of medicine, psychology, counseling, and spirituality. In particular, the author provides recommendations for practitioners who may encounter women presenting with loneliness, and its related symptoms, during the menopausal life stage. Effective treatment of these individuals requires properly informed and compassionate physicians, therapists, and pastors who assess and treat them. Applying the results of this study to these fields will be discussed in the Implications section below, as well as limitations to the study and recommendations for additional research.

Summary of Findings

A variety of physical, cognitive, and emotional symptoms were commonly experienced among participants throughout the menopausal years. These included, but were not limited to, vasomotor symptoms, fatigue, weight gain, decreased libido, foggy brain, anxiety, frustration, anger, isolation, and loneliness. The women in this study also talked about their disillusionment with the medical community who often minimized or overlooked the source of their symptoms or did not help them access appropriate treatment. In addition, every participant described feeling alone in her experience at some point during menopause, if not during the entire process. This

was most often attributed to a lack of education and awareness about what was going on in their bodies, lack of spousal support and validation from doctors, and a lack of normalization from other women who were going through (or had gone through) menopause.

As a result of these changes and experiences, all participants experienced loneliness and developed coping skills to address it. These skills ranged from seeking solitude and times of quiet to socializing with other women in their cohort who could relate to their experience and validate the myriad of symptoms experienced. Specifically, the women in this study identified the following coping skills to address their loneliness during the menopausal years: embracing solitude, practicing faith and perspective-taking, engaging in positive self-talk and social connection, obtaining medical treatment, monitoring diet and exercise, and seeking validation, normalization, and support from other women.

Discussion of Findings

One of the most important conclusions from this study has to do with the correlation between loneliness during the menopausal years and the practice of solitude, faith, perspective-taking, self-talk, and social connection. According to each of the participant's account of these phenomena, loneliness was a direct result of their menopausal experience when these coping skills did not exist, in addition to the lack of education, normalization, and validation received. Conversely, regular practice of solitude, faith, perspective-taking, self-talk, and social connection acted as a moderator on the development or continuance of loneliness in each case. This finding resonates strongly with the observations discussed in the literature review of chapter two, which demonstrated how these specific skills enabled individuals to reduce their experience of loneliness and its associated symptoms, such as depression, frustration, anxiety, negative self-talk, and withdrawal. Additionally, these skills were demonstrated in the Biblical Foundations

portion of this study where biblical characters embraced solitude and counteracted loneliness through prayer, community connection, gratitude, self-talk, and perspective-taking. Recall the admonition from Lamentations 3:28-30 which states “When life is heavy and hard to take, go off by yourself. Enter the silence. Bow in prayer. Don’t ask questions: Wait for hope to appear” (*The Message*, 2002/2010).

While the loneliness experienced during the menopausal years was very real and painful at times, the women in this study also appreciated the value of counteracting their loneliness. Intuitively, they understood that neglecting their physical, cognitive, and emotional selves would only increase or exacerbate these symptoms and that not talking to other women about their experience would cause them to feel more isolated and alone. Because of their willingness to acknowledge this truth, they each sought ways of coping and improving their perspective of the life stage they were in. Although none of these women knew each other, they each reported similar experiences and identified comparable means of coping, utilizing the strengths and insights they already possessed. The key to accessing these skills was education about their menopausal symptoms, normalization about the universality of their experience among women, and validation about the many changes they endured.

Implications

This study demonstrates that there is no need to reinvent the wheel when it comes to treatment of the many physical, cognitive, and emotional symptoms resulting from loneliness during menopause; rather, teaching women to access the skills that have already been shown by other women to effectively reduce loneliness during the menopausal years is recommended. For medical, spiritual, and psychological practitioners working with these women, it is essential to begin by actively listening to their experience and obtaining a thorough understanding of the

context of their symptoms. Not taking the time to do this increases the likelihood of a misdiagnosis, mistreatment, or invalidation of symptoms. Secondly, it is important for practitioners to ask women what skills they already possess or what they have found to be helpful, if anything, in addressing their symptoms. This can lead to a more detailed conversation about the role of solitude, faith, perspective-taking, self-talk, and social connection in reducing the negative side effects of menopause.

Given that the first point of contact for many women during the menopausal years is their gynecologist or primary care doctor, having access to this information and being willing to actively listen to their female patients will allow physicians to provide appropriate referrals to psychological or spiritual practitioners. It is equally important for counselors and other mental health practitioners to be knowledgeable about how loneliness can lead to depression, anxiety, suicidality, and a variety of other cognitive and emotional side effects. As this study demonstrates, it is the convergence of menopausal symptoms with other significant life events unique to this time of life that often leads to the development of loneliness. This is an important distinction from depression or anxiety resulting from other events or psychopathology.

For spiritual counselors and mentors who may talk to women who are struggling with feeling lonely or disconnected from their spouses, partners, family, and community, it is important to ask more probing questions as to the context of this loneliness, such as menopause, launching of children, empty nest syndrome, redefinition of role and identity, and so forth. Obtaining this information will allow those in spiritual roles to normalize and validate women's feelings, while also encouraging them to seek intervention from a medical and/or psychological practitioner. Additionally, a spiritual mentor or counselor can provide insight about how the

Bible normalizes loneliness and addresses it with specific responses, including prayer, community connection, gratitude, self-talk, and perspective-taking.

Limitations

Limitations to this study have to do with the generalizability of participants to a larger menopausal population, especially across culture. Although menopause and loneliness are joint phenomena reported across culture and demographics (Kaur & Kaur, 2021; Ozcan et al., 2022; & Yazdkhasti et al., 2019), those who chose to respond to the recruitment notice may have been more inclined to participate in research studies, had some vested interest, or may have only represented a certain segment of women. Additionally, the participants possessed a high level of education, with each woman enrolled in or having just completed a PhD. Again, the data gathered from this demographic may not be generalizable to all populations. Another possible limitation to generalizability has to do with the fact that each participant described herself as Christian and actively practiced her faith. Having said that, two of the participants did experience a crisis of faith during the menopausal years, one of whom was still uncertain as to her spiritual beliefs at the time of this study.

Additional limitations pertain to retention, the author's bias, and time elapsed. To begin with, retention was an issue during the time elapsed between individual and group interviews. Although the author scheduled these interviews relatively close together and asked participants to agree to both interviews upon providing consent, only three of the ten women were present at the group interview.

Another potential challenge was the possibility of the author's own bias getting in the way in the form of judgments or preconceived ideas. This is why it was essential that the author practice self-awareness and bracket herself from the information shared, as much as possible. It

was also important for the author to suspend judgment or personal beliefs regarding loneliness, its clinical side effects, and best practices for resolving loneliness so that participants could shed light on the coping mechanisms that worked best for them. Finally, it was possible that participants' recollection of events may have been distorted by time and loss of memory. It is this author's belief that recollection of events was fairly accurate, however, due to the fact that all participants were either in the middle of menopause or still experiencing related symptoms even if medically declared to be post-menopausal.

Recommendations for Future Research

The topic of loneliness during the menopausal years is one that can benefit greatly from additional research. While quantitative studies add value, it is recommended that qualitative studies be conducted so that research may benefit from first-hand accounts of women's lived experience of this phenomenon. The three women who participated in the group interview, for example, preferred the qualitative design, stating it allowed them to tell their stories to someone who cared and was interested in their experience. In each of the individual interviews and especially in the group interview, women emphasized the cruciality of continuing this conversation and making the results accessible to others, especially to practitioners. They valued being given an opportunity to vocalize their experience and reported feeling seen and heard, which for several women was the first time they had experienced this type of validation and normalization since embarking on their journey through menopause. Each of the women stated this is a relevant topic that many of their peers are currently discussing and that having this information before menopause would have greatly helped to reduce the development of loneliness and its related symptoms.

Since each of the participants in this study claimed to have an active faith, it is also recommended that future studies go into greater depth about how faith and religious practice help to moderate the development or continuance of loneliness during the menopausal years. Specifically, future research could explore whether the pre-existence of faith allows women to access coping skills sooner or more easily, or whether the experience of loneliness and its related symptoms inclines women toward faith and other related coping skills.

Finally, there were some unintended results to this study, specifically the presence of other life events during the menopausal years that may have contributed to the development of loneliness. These included divorce, physical issues such as a blood disorder, cancer, Celiac disease, and a brain tumor, military relocations, job relocations, family trauma, the loss of a spouse and children, and the loss of parents. It is recommended that additional research focus on how unanticipated life events or traumatic losses also affect women during the menopausal years and whether those women suffer more from loneliness as opposed to a control group who has not experienced these types of losses or stressors.

Summary

The menopausal years are known to bring both social and emotional loneliness for many women, which compounded with the vast physical and familial changes at this time of life, can lead to high levels of depression and anxiety (Kaur & Kaur, 2021; Maes et al., 2019; Ozcan et al., 2022). Menopause often coincides with physical and sexual changes, launching of children from the home, and reevaluation of a woman's purpose and meaning (East et al., 2017; Gadban & Goldner, 2020; Guthrie-Gower & Wilson-Menzfeld, 2022; Kaur & Kaur, 2021; Lee et al., 2019; Ozcan et al., 2022; Pineros-Leano et al., 2021, & Yazdkhasti et al., 2019). In fact, Ozcan et al. (2022) found that 99% of women did not view menopause as a normal life process and

expressed fears of losing their beauty, femininity, role, and significance once they were no longer able to have children or had raised their children. Their study also revealed that menopausal women felt increasingly lonely and suffered from a displaced sense of self and purpose.

Given the risk of depression, anxiety, and disillusionment associated with loneliness, symptoms which can also foster shame and make it difficult for women to seek help, it is important this period of the lifespan not be overlooked. Understanding the root cause of women's varying emotions and loneliness during this life stage is essential for effective prevention and intervention. While the women in this study described significant physical, cognitive, and emotional side effects of menopause, they also sought relief through the intuitive practice of solitude, faith, perspective-taking, self-talk, and social connection. Key factors that enabled women to access these skills had to do with the normalization and validation of their experience, which was needed from partners, peers, medical practitioners, and therapists. By being educated and well-versed about menopause, its many side effects, and its propensity for being a catalyst for the development of loneliness, medical, spiritual, and psychological practitioners can help to more quickly identify the source of loneliness and advocate for appropriate treatment.

REFERENCES

Abedi, P., Afshari, P., Yaralizadeh, M., & Dastoorpoor, M. (2020). Does loneliness following empty nest impair sexual function and satisfaction of middle-aged Iranian women? *Sexuality and Culture, 24,* 2045-2055. https://doi.org/10.1007/s12119-020-09735-3

Achdut, N. & Refaeli, T. (2021). An ethnocultural perspective on loneliness in young adulthood: A population-based study in Israel. *Sociology of Health and Illness, 43,* 1154-1174. DOI: 10.1111/1467-9566.13277

Adamczyk, K., Park, J. Y., & Segrin, C. (2022). Patterns of intimacy crisis resolution and their association with romantic loneliness in Polish and U.S. young adults. *Developmental Psychology, 58*(8), 1600-1613. https://doi.org/10.1037/dev0001371

Arbuckle, G. A. (2022). From loneliness to solitude: Biblical reflections. *Australasian Catholic Record, 99*(3), 333-346. https://go.openathens.net/redirector/liberty.edu?url=https://www.proquest.com/scholarly-journals/loneliness-solitude-biblical-reflections/docview/2706867431/se-2

Arimoto, A. & Tadaka, E. (2021). Individual, family, and community factors related to loneliness in mothers raising children less than three years of age: A cross-sectional study. *BMC Women's Health, 21*(226), 1-11. https://doi.org/10.1186/s12905-021-01365-7

Augustijn, L. (2021). The intergenerational transmission of loneliness between parents and their adult children. *Journal of Family Research, 33*(1), 1-21. doi: 10.20377/jfr-365

Austin, P., Macdonald, J., & MacLeod, R. (2018). Measuring spirituality and religiosity in clinical settings: A scoping review of available instruments. *Religions, 9*(70), 1-14. doi:10.3390/rel9030070

Batcho, K. I. (2021). The role of nostalgia in resistance: A psychological perspective. *Qualitative Research in Psychology, 18*(2), 227-249. https://doi.org/10.1080/14780887.2018.1499835

Birditt, K. S., Manalel, J. A., Sommers, H., Luong, G., & Fingerman, K. L. (2019). Better off alone: Daily solitude is associated with lower negative affect in more conflictual social networks. *The Gerontologist, 59*(6), 1152-1161. doi:10.1093/geront/gny060

Bjørge, H., Sæteren, B., & Ulstein, I. D. (2019). Experiences of companionship among family caregivers of persons with dementia: A qualitative study. *Dementia, 18*(1), 228-244. https://uk.sagepub.com/en-gb/journals-permissions

Borawski, D. (2022). The mediating role of positive orientation in the relationship between loneliness and meaning in life. *International Journal of Environmental Research and Public Health, 19*, 1-8. https://doi.org/10.3390/ijerph19169948

Borawski, D. (2022). When you are lonely, look inside yourself: The moderating role of reflection in the relationship between loneliness and meaning in life. *Personality and Individual Differences, 194*, 1-6. https://doi.org/10.1016/j.paid.2022.111662

Brinthaupt, T. M. (2019). Individual differences in self-talk frequency: Social isolation and cognitive disruption. *Frontiers in Psychology, 10*(1088), 1-7. https://www.frontiersin.org/journals/psychology#editorial-board

Brown, S. & Munson, M. R. (2020). Introduction to the special issue on social isolation across the lifespan. *Clinical Social Work Journal, 48,* 1-5. https://doi.org/10.1007/s10615-020-00750-3

Bussing, A. (Ed.) (2021). *The spiritual needs questionnaire: Implications for health and social care.* Palgrave.

Creswell, J. W. & Poth, C. N. (2018). *Qualitative inquiry and research design: Choosing among five approaches* (5th ed.). Sage.

Curran, E., Rosato, M., Cooper, J., McGarrigle, C. A., & Leavey, G. (2019). Symptom profiles of late-life anxiety and depression: The influence of migration, religion and loneliness. *Depression and Anxiety, 36*(9), 824-833. https://doi.org/10.1002/da.22893

Davis, S. K., Nowland, R., & Qualter, P. (2019). The role of emotional intelligence in the maintenance of depression symptoms and loneliness among children. *Frontiers in Psychology, 10*(1672), 1-12. doi:10.3389/fpsyg.2019.01672

DeRobertis, E. M. & Bland, A. M. (2019). Lifespan human development and "The humanistic perspective": A contribution toward inclusion. *The Humanistic Psychologist, 48*(1), 3-27. http://dx.doi.org/10.1037/hum0000141

East, P., Blanco, E., Delker, E., Encina, P., Lozoff, B., Delva, J., & Gahagan, S. (2017). Infant iron deficiency, child affect, and maternal unresponsiveness: Testing the long-term effects of functional isolation. *Developmental Psychology, 53*(12), 2233-2244. http://dx.doi.org/10.1037/dev0000385

Elmer, T., Geschwind, N., Peeters, F., Wichers, M., & Bringmann, L. (2020). Getting stuck in social isolation: Solitude inertia and depressive symptoms. *Journal of Abnormal Psychology, 129*(7), 713-723. http://dx.doi.org/10.1037/abn0000588

Fakoya, O. A., McCorry, N. K., & Donnelly, M. (2021). How do befriending interventions alleviate loneliness and social isolation among older people? A realist evaluation study. *PlosOne, 16*(9), 1-21. https://doi.org/10.1371/journal.pone.0256900

Foster, A., Thompson, J., Holding, E., Ariss, S., Mukuria, C., Jacques, R., Akparido, R., & Haywood, A. (2020). Impact of social prescribing to address loneliness: A mixed methods evaluation of a national social prescribing programme. *Health and Social Care in the Community, 29,* 1439-1449. DOI: 10.1111/hsc.13200

Franssen, T., Stijnen, M., Hamers, F., & Schneider, F. (2020). Age differences in demographics, social and health-related factors associated with loneliness across the adult life span (19-65 years): A cross-sectional study in The Netherlands. *BMC Public Health, 20*(1118), 2-12. https://doi.org/10.1186/s12889-020-09208-0

French, D. C., Purwono, U., & Shan, M. (2022). Religiosity and positive religious coping as predictors of Indonesian Muslim adolescents' externalizing behavior and loneliness. *Psychology of Religion and Spirituality, 14*(2), 189-199. http://dx.doi.org/10.1037/rel0000300

Gadban, F. & Goldner, L. (2020). "I have no hope": The experience of mothers in polygamous families as manifested in drawings and narratives. *Frontiers in Psychology, 11,* 1-10. doi:10.3389/fpsyg.2020.608577

Galla, B. M., Tsukayama, E., Park, D., Yu, A., & Duckworth, A., (2020). The mindful

adolescent: Developmental changes in nonreactivity to inner experiences and its association with emotional well-being. *Developmental Psychology*, *56*(2), 350-363. https://doi.org/10.1037/dev0000877

Gibbes, S. (2022). A crisis of community: How an epidemic of loneliness is contributing to social disconnection in churches. *Practical Theology*, *15*(3), 258-271. https://www.tandfonline.com/loi/yprt20

Guest, G., Bunce, A., & Johnson, L. (2006). How many interviews are enough? An experiment with data saturation and variability. *Field Methods*, *18*(1), 59-82. DOI:10.1177/1525822X05279903

Guthrie-Gower, S. & Wilson-Menzfeld, G. (2022). Ex-military personnel's experiences of loneliness and social isolation from discharge, through transition, to the present day. *PlosOne, 17*(6), 1-17. https://doi.org/10.1371/journal.pone.0269678

Han, S., Hu, Y., Wang, L., Pei, Y., Zhu, Z., Qi, X., & Wu, B. (2021). Perceived discrimination and mental health symptoms among persons living with HIV in China: The mediating role of social isolation and loneliness. *AIDS Care*, *33*(5), 575-584. https://doi.org/10.1080/09540121.2020.1847246

Hemberg, J., Korzhina, Y., Groundstroem, H., Ostman, L., Nystrom, L., & Nyman-Kurkiala, P. (2021). Loneliness—two sides to the story: Adolescents' lived experiences. *International Journal of Adolescence and Youth, 26*(1), 41-56. https://doi.org/10.1080/02673843.2021.1883075

Heu, L. C., Hansen, N., van Zomeran, M., Levy, A., Ivanova, T. T., Gangadhar, A., & Radwan, M. (2021). Loneliness across cultures with different levels of social

embeddedness: A qualitative study. *Personal Relationships, 28,* 379-405. DOI: 10.1111/pere.12367

Hwang, J., Wang, L., Siever, J., DelMedico, T., & Jones, C. A. (2019). Loneliness and social isolation among older adults in a community exercise program: A qualitative study. *Aging and Mental Health, 23*(6), 736-742. https://doi.org/10.1080/13607863.2018.1450835

Jenkins, S. G., Janich, N., Wu, S., & Shafer, M. (2022). Social isolation and mental health: Evidence from adults with serious mental illness. *Psychiatric Rehabilitation Journal*, 1-8. https://dx.doi.org/10.1037/prj0000554

Jovicic, A. & McPherson, S. (2019). To support and not to cure: General practitioner management of loneliness. *Health and Social Care in the Community, 28,* 376-384. DOI:10.1111/hsc.12869

Kall, A., Lindegaard, T., Cooper, Z., Shafran, R., Bennett, S., Coughtrey, A., & Andersson, G. (2020). Common elements approach to the development of a modular cognitive behavioral theory for chronic loneliness. *Journal of Consulting and Clinical Psychology, 88*(3), 269-282. http://dx.doi.org/10.1037/ccp0000454

Kang, Y., Cosme, D., Pei, R., Pandey, P., Carreras-Tartak, J., & Falk, E. B. (2021). Purpose in life, loneliness, and protective health behaviors during the COVID-19 pandemic. *The Gerontologist, 61*(6), 878-887. doi:10.1093/geront/gnab081

Kaur, M. & Kaur, J. (2021). Reality therapy: A boon to recuperate from empty nest syndrome. *International Journal of Choice Theory and Reality Therapy, 40*(2), 46-62. https://go.openathens.net/redirector/liberty.edu?url=https://www.proquest.com/scholarly-journals/reality-therapy-boon-recuperate-empty nest/docview/2596634375/se-2

Kent-Marvick, J., Simonsen, S., Pentecost, R., Taylor, E., & McFarland, M. M. (2022). Loneliness in pregnant and postpartum people and parents of children aged 5 years or younger: A scoping review. *Systematic Reviews, 11*(196), 1-14. https://doi.org/10.1186/s13643-022-02065-5

Kahn, A., Khan, S., & Burton, N. (2021). Insufficient physical activity and high sedentary behavior are associated with loneliness in adolescents with overweight/obesity: Evidence from 23 low- and middle-income countries. *Pediatric Obesity, 17*(2), 1-4. https://doi.org/10.1111/ijpo.12836

King, M. (2018). Working to address the loneliness epidemic: Perspective-taking, presence, and self-disclosure. *American Journal of Health Promotion, 32*(5), 1315-1317. DOI:10.1177/0890117118776735c

Knopf, A. (2020). Prepare for increased depression, anxiety in youth due to COVID-19 lockdown. *The Brown University Child and Adolescent Psychopharmacology Update, 22*(8), 1-4. doi: 10.1016/j.jaac.2020.05.009.

Lee, K., Vasileiou, K., & Barnett, J. (2019). 'Lonely within the mother': An exploratory study of first-time mothers' experiences of loneliness. *Journal of Health Psychology, 24*(10), 1334-1344. DOI:10.1177/1359105317723451

Leontiev, D. (2019). The dialectics of aloneness: Positive vs. negative meaning and differential assessment. *Counseling Psychology Quarterly, 32*(3-4), 548-562. https://doi.org/10.1080/09515070.2019.1640186

Lerner, R. M., Overton, W. F. & Molenaar, P.C.M. (Eds.) (2015) *Handbook of child psychology and developmental science, Vol. 1: Theory and method* (7th ed.). John Wiley & Sons.

Lippke, S., Fischer, M. A., & Ratz, T. (2021). Physical activity, loneliness, and meaning of friendship in young individuals – A mixed-methods investigation prior to and during the COVID-19 pandemic with three cross-sectional studies. *Frontiers in Psychology, 12*(617267), 1-13. https://www.frontiersin.org/journals/psychology#editorial-board

Liu, G., Li, S., & Kong, F. (2022). Association between sense of belonging and loneliness among the migrant elderly following children in Jinan, Shandong Province, China: The moderating effect of migration pattern. *International Journal of Environmental Research and Public Health, 19*(4396), 1-13. https://doi.org/10.3390/ijerph19074396

Luoma, I., Korhonen, M., Puura, K., & Salmelin, R. K. (2019). Maternal loneliness: Concurrent and longitudinal associations with depressive symptoms and child adjustment. *Psychology, Health and Medicine, 24*(6), 667-679. https://doi.org/10.1080/13548506.2018.1554251

Mack, N., Woodsong, C., MacQueen, K. M., Guest, G., & Namey, E. (2005). *Qualitative research methods: A data collector's filed guide.* Family Health International.

Maes, M., Qualter, P., Vanhalst, J., Van den Noortgate, W., & Goossens, L. (2019). Gender differences in loneliness across the lifespan: A meta-analysis. *European Journal of Personality, 33*, 642-654. DOI:10.1002/per.2220

McComb, S. E., Goldberg, J. O., Flett, G. L., & Rose, A. L. (2020). The double jeopardy of feeling lonely and unimportant: State and trait loneliness and feelings and fears of not mattering. *Frontiers in Psychology, 11*, 1-8. doi:10.3389/fpsyg.2020.563420

McKenna-Plumley, P. E., Graham-Wisener, L., Berry, E., & Groarke, J. M. (2021). Connection, constraint, and coping: A qualitative study of experiences of loneliness

during the COVID-19 lockdown in the UK. *PlosOne, 16*(10), 1-18. https://doi.org/10.1371/journal.pone.0258344

McKenna-Plumley, P. E., Groarke, J. M., Turner, R. N., & Yang, K. (2020). Experiences of loneliness: A study protocol for a systematic review and thematic synthesis of qualitative literature. *Systematic Reviews, 9,* 284, 1-8. https://doi.org/10.1186/s13643020-01544-x

Minkin, M. J. (2019). Menopause: Hormones, lifestyle, and optimizing age. *Obstetrics and Gynecology Clinics of North America, 46*(3), 501-514. https://doi.org/10.1016/j.ogc.2019.04.008

Mund, M., Freuding, M. M., Mobius, K., Horn, N., & Neyer, F. J. (2020). The stability and change of loneliness across the life span: A meta-analysis of longitudinal studies. *Personality and Social Psychology Review, 24*(1), 24-52. https://doi.org/10.1177/1088868319850738

Mund, M., Ludtke, O., and Neyer, F. J. (2020). Owner of a lonely heart: The stability of loneliness across the life span. *Journal of Personality and Social Psychology: Personality Differences and Individual Differences, 119*(2), 497-516. http://dx.doi.org/10.1037/pspp0000262

Mund, M. & Neyer, F. J. (2019). Loneliness effects on personality. *International Journal of Behavioral Development, 43*(2), 136-146. https://doi.org/10.1177/0165025418800224

Nelson, T., Cardemil, E. V., Overstreet, N. M., Hunter, C. D., & Woods-Giscombe, C. L. (2022). Association between superwoman schema, depression, and resilience: The mediating role of social isolation and gendered racial centrality. *Cultural Diversity and Ethnic Minority Psychology,* 1-12. https://doi.org/10.1037/cdp0000533

Nguyen, T. T., Ryan, R. M., & Deci, E. L. (2018). Solitude as an approach to affective self-regulation. *Personality and Social Psychology Bulletin, 44*(1), 92-106. https://doi.org/10.1371/journal.pone.0256900

Oles, P. K., Brinthaupt, T. M., Dier, R., & Polak, D. (2020). Types of inner dialogues and functions of self-talk: Comparisons and implications. *Frontiers in Psychology, 11*(227), 1-10. https://www.frontiersin.org/journals/psychology#editorial-board

O'Shea, E. R., Phillips, K. E., O'Shea, K. N., & Roney, L. N. (2022). Preparing for the impact of COVID-19 on the mental health of youth. *NASN School Nurse*, 64-49. DOI: 10.1177/1942602X211052626

Ozcan, H., Savci, H., Canik, M., Ayan, M., & Bas, C. F. (2022). Comparison of the relationship between menopausal symptoms and loneliness and anger. *Perspectives in Psychiatric Care, 58,* 1900-1906. DOI: 10.1111/ppc.13004

Paredes, A. M., Lee, E. E., Chik, L., Gupta, S., Palmer, B. W., Palinkos, L. A., Kim, H-C., & Jeste, D. V. (2021). Qualitative study of loneliness in a senior housing community: The importance of wisdom and other coping strategies. *Aging and Mental Health, 25*(3), 559-566. https://doi.org/10.1080/13607863.2019.1699022

Pearce, E., Barreto, M., Victor, C., Hammond, C., Eccles, A. M., Richins, M. T., O'Neil, A., Knowles, M. L., & Qualter, P. (2022). Choking under pressure: Does it get easier with age? How loneliness affects social monitoring across the life span. *International Journal of Behavioral Development, 46*(1), 50-62. DOI:10.1177/0165025420979369

Pineros-Leano, M., Yao, L., Simonovich, S. D., Pineros-Leano, N., Huang, M. (2021). "I don't have time to be sad": Expressions and perceptions of sadness among Latina mothers. *Social Work, 66*(2), 119-127. doi: 10.1093/sw/swab008

Preece, D. A., Goldenberg, A., Becerra, R., Boyes, M., Hasking, P., & Gross, J. J. (2021). Loneliness and emotion regulation. *Personality and Individual Differences, 180,* 1-7. https://doi.org/10.1016/j.paid.2021.110974

Prinzing, M., Van Cappellen, P., & Fredrickson, B. L. (2023). More than a momentary blip in the universe? Investigating the link between religiousness and perceived meaning in life. *Personality and Social Psychology Bulletin, 49*(2), 180-196. DOI:10.1177/01461672211060136

Purswell, K. E. (2019). Humanistic learning theory in counselor education. *The Professional Counselor, 9*(4), 358-368. doi:10.15241/kep.9.4.358

Raque-Bogdan, T. L., Lamphere, B., Kostiuk, M., Gissen, M., & Beranek, M. (2019). Unpacking the layers: A meta-ethnography of cancer survivors' loneliness. *Journal of Cancer Survivorship, 13,* 21-33. https://doi.org/10.1007/s11764-018- 0724-6

Raw, J. A. L., Waite, P., Pearcey, S., Shum, A., Patalay, P., & Creswell, C. (2021). Examining changes in parent-reported child and adolescent mental health throughout the UK's first COVID-19 national lockdown. *The Journal of Child Psychology and Psychiatry, 62*(12), 1391-1401. doi:10.1111/jcpp.13490

Ross, A. M., Devoe, E. R., Steketee, G., Spencer, R., & Richter, M. (2021). "This is not your life…and it becomes your life": A qualitative exploration of deployment-related stress and support needs in National Guard and Reserve spouses who are mothers of young children. *Family Process, 60*(4), 1364-1380. doi: 10.1111/famp.12622

Salo, A-E., Junttila, N., & Vauras, M. (2020). Social and emotional loneliness: Longitudinal stability, interdependence, and intergenerational transmission among boys and girls.

Family Relations: Interdisciplinary Journal of Applied Family Science, 69, 151-165. DOI:10.1111/fare.12398

Stahl, N. A. & King, J. R. (2020). Expanding approaches for research: Understanding using trustworthiness in qualitative research. *Journal of Developmental Education, 44*(1), 26 28. https://files.eric.ed.gov/fulltext/EJ1320570.pdf

Strong, J. (1990). *The new Strong's exhaustive concordance of the Bible.* Thomas Nelson.

Tagomori, H., Fardghassemi, S., & Joffe, H. (2022). How young adults cope with loneliness: A study of London's most deprived boroughs. *International Journal of Adolescence and Youth, 27*(1), 1-22. https://doi.org/10.1080/02673843.2021.2013263

Teneva, N. & Lemay, E. P. (2020). Projecting loneliness into the past and future: Implications for self-esteem and affect. *Motivation and Emotion, 44*, 772-784. https://doi.org/10.1007/s11031-020-09842-6

The Message Bible. (2010). Eugene H. Peterson.

Thomas, V. (2023). Solitude skills and the private self. *Qualitative Psychology, 10*(1), 121-139. https://doi.org/10.1037/qup0000218

Thomas, V. & Azmitia, M. (2019). Motivation matters: Development and validation of the Motivation for Solitude Scale – Short Form (MSS-SF). *Journal of Adolescence, 70*(2019), 33-42. https://doi.org/10.1016/j.adolescence.2018.11.004

Trevino, K., M., Pargament, K. I., Krause, N., Ironson, G., & Hill, P. (2019). Stressful events and religious/spiritual struggle: Moderating effects of the general operating system. *Psychology of Religion and Spirituality, 11*(3), 214-224. http://dx.doi.org/10.1037/rel0000149

Valliani, K. & Mughal, F. B. (2022). Human emotions during covid-19: A lens through Kubler Ross grief theory. *American Psychological Association, 14*(2), 247-249. https://doi.org/10.1037/tra0001064

Wetzel, B., Pryss, R., Baumeister, H., Edler, J-S., Oliveira Goncalves, A. S., & Cohrdes, C. (2021). "How come you don't call me?" Smartphone communication app usage as an indicator of loneliness and social well-being across the adult lifespan during the COVID-19 pandemic. *International Journal of Environmental Research and Public Health, 18*(6212), 1-18. https://doi.org/10.3390/ijerph18126212

Williams, B. (2022). Understanding loneliness and its relationship with mental health issues. *Mental Health Practice, 25*(3), 16-21. doi: 10.7748/mhp.2022.e1601

Yazdkhasti, M., Negarandeh, R., & Moghadam, Z. B. (2019). An empowerment model of Iranian women for the management of menopause: A grounded theory study. *International Journal of Qualitative Studies on Health and Well-Being, 14*, 1-11. https://doi.org/10.1080/17482631.2019.1665958

Zoom Video Communications. (2023). *Audio transcription for cloud recordings.* https://support.zoom.com/hc/en/article?id=zm_kb&sysparm_article=KB0064927#:~:text=To%20generate%20a%20transcript%2C%20start,for%20the%20recording%20is%20available.

Appendix A

Recruitment Notice

Dear Potential Participant,

As a doctoral candidate in the Developmental Psychology Department at Liberty University, I am conducting research as part of the requirements for a PhD. The purpose of my research is to better understand women's experience of loneliness during the menopausal years, as well as to learn which coping skills they have utilized to help reduce loneliness, and I am writing to invite you to join my study.

Participants must be:

- Female
- Between the ages of 40 and 60 years old
- Have at least one child
- Currently be in perimenopause, menopause, or through menopause
- Experiencing (or have experienced) loneliness during this life stage

In addition, you must have access to a computer and internet connection. Please refrain from participation in this study if you are currently suffering from any detrimental mental health condition(s) which remains untreated, including suicidality or active self-harm. Taking part in this research project is voluntary.

Participants will be asked to:

1. Complete an online demographic survey that will take five minutes.
2. Participate in an individual tele-video, audio-recorded interview that will take no more than 60 minutes.
3. Participate in a second tele-video, audio-recorded group interview with all other participants in the study that will take no more than 60 minutes.

Names and identifying information will be requested as part of this study, but participant identities will not be disclosed.

If you are interested in being a participant in this study and meet the above participant criteria, please respond to me by email at [redacted] and I will email you a screening survey to determine your eligibility for this study. Once eligibility is determined, I will follow up by emailing you a consent form and demographic survey. Upon completion of these steps, I will contact you by phone to schedule an individual interview.

Thank you for your time and consideration of this study.

Sincerely,

Sarah Groff
Doctoral Candidate, Developmental Psychology, Liberty University Online
[redacted]

Appendix B

Screening Survey

Dear Potential Participant,

Thank you for expressing interest in my doctoral study about menopause and loneliness. If you meet the criteria listed below, please click on this link to complete the screening survey: https://forms.gle/QB8M3i3MZ3WiWE8G9. Once I have received your results and if you are determined eligible, I will be in touch with the consent form and demographic survey. Following these steps, your individual interview will be scheduled.

Participants must be:

- Female
- Between the ages of 40 and 60 years old
- Have at least one child
- Currently be in perimenopause, menopause, or through menopause
- Experiencing (or have experienced) loneliness during this life stage

In addition, you must have access to a computer and internet connection. Please refrain from participation in this study if you are currently suffering from any detrimental mental health condition(s) which remains untreated, including suicidality or active self-harm.

Thank you for your time and consideration. I look forward to working with you!

Sincerely,

Sarah Groff
Doctoral Candidate, Developmental Psychology, Liberty University Online
[redacted]

Appendix C

Follow-up Email with Consent Form and Demographic Survey

Dear Participant,

You have been selected to participate in my doctoral study about the experience of loneliness during the menopausal years. According to your screening survey, you meet the participant criteria for this study and the next step is for you to complete the consent form and demographic survey.

Please click here https://forms.gle/49Ybo1bCK7FSuem89 to complete the demographic survey.

The consent form is attached to this email and contains additional information about my research. After reading it thoroughly and addressing any questions you may have directly with me, please sign and return it by email to [redacted].

I will need to receive both the above documents prior to scheduling your individual interview. Thank you so much for your time. I look forward to working with you!

Sincerely,

Sarah Groff
Doctoral Candidate, Developmental Psychology, Liberty University Online
[redacted]

Appendix D

Consent Form

Title of the Project: Perspective-taking, Self-talk, and Social Connection: A Phenomenological Study of how Individual Practices Reduce Loneliness During the Menopausal Years
Principal Investigator: Sarah Groff, Doctoral Candidate, School of Developmental Psychology, Liberty University Online

You are invited to participate in a research study. To participate, you must be:

- Female
- Between the ages of 40 and 60 years old
- Have at least one child
- Currently be in perimenopause, menopause, or through menopause
- Experiencing (or have experienced) loneliness during this life stage

In addition, you must have access to a computer and internet connection. Please refrain from participation in this study if you are currently suffering from any detrimental mental health condition(s) which remains untreated, including suicidality or active self-harm. Taking part in this research project is voluntary.

Please take time to read this entire form and ask questions before deciding whether to take part in this research.

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

The purpose of this study is to better understand women's experience of loneliness during the menopausal years, as well as to learn which coping skills they have utilized to help reduce loneliness.

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. Complete an online demographic survey that will take five minutes.
2. Participate in an individual tele-video, audio-recorded interview that will take no more than 60 minutes.
3. Participate in a second tele-video, audio-recorded group interview with all other participants in the study that will take no more than 60 minutes.

How could others benefit from this study?

The direct benefits participants should expect to receive from taking part in this study include the opportunity to talk about their lived experience, to receive validation about many of the

feelings and changes associated with this stage of life, and to have these feelings normalized as part of a larger group of women who have gone through similar experiences.

Benefits to society include an increased understanding of the experience of loneliness during the menopausal years and subsequent validation and normalization of this experience. The information gained in this study will also contribute to the existing body of literature on this topic. Furthermore, the information gained in this study will be made available to medical and mental health practitioners to improve their assessment and treatment of women who present with symptoms related to this experience.

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 in this study include psychological stress from being asked to recall and discuss your experience of loneliness during the menopausal years and any related symptoms of depression or anxiety associated with this experience. To reduce risk, I will monitor your emotional response during interviews, discontinue the interview if needed, and provide referral information for counseling services.

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 to the online demographic survey and responses during interviews will be kept confidential by replacing names with pseudonyms and interviews will be conducted via a web-based platform to ensure privacy and the inability of others to overhear the conversation.
- Confidentiality cannot be guaranteed in group settings. While discouraged, other members of the group interview may share what was discussed with persons outside of the group.
- Data will be stored on a password-locked computer and external hard drive stored in a locked and coded safe. After seven years, all electronic records will be deleted.
- Recordings will likewise be stored on a password-locked computer for seven years and then deleted. The researcher and members of her doctoral committee will have access to these recordings.

Is study participation voluntary?

Participation in this study is voluntary. Your decision whether to participate will not affect your current or future relations with Liberty University. If you decide to participate, you are free to not 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 exit the online demographic survey and close your internet browser. Your responses will not be recorded or included in the study. If you choose to withdraw from the study following completion of the online demographic survey, please contact the researcher at the email address included in the next paragraph. Should you choose to withdraw, data collected from you, apart from the group interview data, will be destroyed immediately and will not be included in this study. Group interview data will not be destroyed, but your contributions to the group interview will not be included in the study if you choose to withdraw.

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

The researcher conducting this study is Sarah Groff. 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, Dr. Busarow, 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 would like 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.

Your Consent

By signing this document, you are agreeing to be in this study. Make sure you understand what the study is about before you sign. You can print a copy of this document for your records. The researcher will keep a copy with the study records. If you have any questions about the study after you sign this document, you can contact the study team using the information provided above.

I have read and understood the above information. I have asked questions and have received answers. I consent to participate in the study.

☐ The researcher has my permission to audio-record me as part of my participation in this study.

_____
Printed Subject Name

_____
Signature and Date

Appendix E

Demographic Survey

Please fill in the blanks.

1. What is your age (in years)? _____
2. What is your race or ethnicity? _____
3. What is your cultural identity? (Optional) _____
4. How many children do you have? _____
5. Have any of your children launched from the home? _____
6. What was your age (in years) at the onset of perimenopause or menopause? _____
7. Briefly describe any physical, mental, or emotional side effects associated with perimenopause or menopause. _____

_____

_____

_____

_____

8. List any current physical or mental health diagnoses and whether (and what type) of treatment you receive for these conditions, including medication or talk therapy.

_____

_____

_____

_____

_____

_____

Appendix F

Follow-Up Recruitment Email

Dear Potential Participant,

As a doctoral candidate in the Developmental Psychology Department at Liberty University, I am conducting research as part of the requirements for a PhD. Two weeks ago an email was sent to you inviting you to participate in a research study. This follow-up email is being sent to remind you to complete the survey if you would like to participate and have not already done so. The deadline for participation is _____.

Participants must be:

- Female
- Between the ages of 40 and 60 years old
- Have at least one child
- Currently be in perimenopause, menopause, or through menopause
- Experiencing (or have experienced) loneliness during this life stage

In addition, you must have access to a computer and internet connection. Please refrain from participation in this study if you are currently suffering from any detrimental mental health condition(s) which remains untreated, including suicidality or active self-harm.

Participants will be asked to:

1. Complete an online demographic survey that will take five minutes.
2. Participate in an individual tele-video, audio-recorded interview that will take no more than 60 minutes.
3. Participate in a second tele-video, audio-recorded group interview with all other participants in the study that will take no more than 60 minutes.

Names and identifying information will be requested as part of this study, but participant identities will not be disclosed.

To participate, please click here https://forms.gle/49Ybo1bCK7FSuem89 to complete the attached demographic survey and return it by email to [redacted]. If you meet my participant criteria, I will contact you to schedule an interview and email you potential questions to help you prepare for the interview.

A consent document is provided in the first several pages of the survey attached to this email. The consent document contains additional information about my research.

If you choose to participate, you will need to sign the consent document and return it to me prior to scheduling your first individual interview.
Sincerely,

Sarah Groff
Doctoral Candidate, Developmental Psychology, Liberty University Online
[redacted]

Appendix G

Individual Interview Questions

RQ1:

1) Describe your experience of the menopausal life stage.

2) Tell me about a time you experienced loneliness during this life stage.

RQ2:

1) Describe a skill(s) that has helped you to cope with loneliness during this stage of life.

2) Describe your experience with solitude and how you benefit from this time, if applicable.

3) Describe your faith and spiritual practice. How does this help address loneliness for you?

4) How does perspective-taking help you to alleviate loneliness?

5) Describe your self-talk when alone and/or when you are feeling lonely.

6) Describe your engagement in social connection? How does this help address loneliness for you?

Appendix H

Group Interview Questions

1) Describe how your perspective of yourself and your role in life changed during this life stage?
2) What additional insights have you gained from your experience?
3) What suggestions, if any, do you have for other women who are going through menopause or who are approaching this stage of life?
4) Please describe your experience of the data gathering process during this study.
5) If you require additional intervention to help manage the symptoms of loneliness, please feel free to contact me privately at [redacted] and I will be happy to discuss possible treatment options with you.

Appendix I

Semi-Structured Interview Protocol

Participant ID: _____ Interview #: _____

Date: _____ Time: _____

Prior to the interview make sure all recording and transcription devices are functioning properly.

Introduction to interview (The following is a script for the interviewer to use with participants):

Hello _____ (*insert participant's name*), my name is Sarah Groff. It is so nice to meet you and I appreciate your time and willingness to participate in this interview today. As a reminder, I am a doctoral student in the developmental psychology program at Liberty University. I want to make sure you have my contact information in the event we have any interruptions today or you have future questions or concerns regarding the research process. This information is also outlined in your consent form. (*Provide contact information.*)

Before we begin, I want to give you a better idea of what to expect. We will spend approximately 60 minutes together today, during which time I will be asking questions like those you received in the email I sent you upon acceptance into the study. As stated previously, the purpose of this research study is to better understand women's experience of loneliness during the menopausal years, as well as to learn which coping skills they have utilized to help reduce loneliness.

During today's interview, I will be asking you questions about your personal experience and I invite you to be as transparent as possible. Keep in mind there are no right or wrong answers, as I am hoping to learn from you. I will be taking notes while we talk, as well as audio recording our conversation for additional reference later. I recognize this conversation may trigger emotions at times, which is completely welcomed; however, if you feel uncomfortable or upset at any time, please let me know so that we can either pause or move on to a different question. You are under no obligation to complete or participate in this study, so please let me know if you wish to take a break or terminate the interview at any time. I am also a licensed clinical therapist, so I am available to offer emotional support, as well, should you desire my assistance during this interview. (*Allow for any questions or clarification.*)

Thank you again for choosing to participate in this study. I am looking forward to learning more during this interview. At this time, I will begin recording.

Start the recording/transcription device and begin interview

1) Describe your experience of the menopausal life stage.
2) Tell me about a time you experienced loneliness during this life stage.
3) Describe a skill(s) that has helped you to cope with loneliness during this stage of life.

4) Describe your experience with solitude and how you benefit from this time, if applicable.
5) Describe your faith and spiritual practice. How does this help address loneliness for you?
6) How does perspective-taking help you to alleviate loneliness?
7) Describe your self-talk when alone and/or when you are feeling lonely.
8) Describe your engagement in social connection? How does this help address loneliness for you?

Termination of Interview

Thank you so much for your time today, _____ (*insert participant name*), and for sharing your story with me. It may be necessary for me to contact you again in the event I have any points that need clarifying. Would that be okay? I will also be talking with you once more in our group interview (to be scheduled). As stated previously, you are more than welcome to reach out to me with any questions or concerns you may have regarding this research study.

(*This final statement may be included, if necessary*): If you know of anyone else who may be interested or eligible to participate in this study, please feel free to pass my information on to them.

End recording and transcription

Appendix J

Transcription Protocol

(Mack et al., 2005)

Transcribe all tapes verbatim (that is, word-for-word, exactly as words were spoken).

Indicate all nonverbal or background sounds in parentheses. This includes laughter, sighs, coughs, clapping, snapping of fingers, pen clicking, car horn, birds, etc. For example: (short sharp laugh), (group laughter), or (police siren in background).

Do not "clean up" the transcript by removing foul language, slang, grammatical errors, or mis-used words or concepts.

Transcribe any mispronounced words exactly as the interviewer or participant pronounced them. If a transcribed mispronunciation risks causing problems with the reader's comprehension of the text, use the following convention: [/word as it would correctly be pronounced/]. (For translation, mispronunciations will be ignored and only the correct translation will be provided.) For example:

> I thought that was pretty pacific [/specific/], but they disagreed.

Standardize the spelling of key words, blended or compound words, common phrases, and identifiers across all interview and focus group transcripts.

Transcribe both standard contractions (e.g., contractions of the following words: is, am, are, had, have, would, or not) **and nonstandard contractions** (e.g., betcha, cuz, 'em, gimme, gotta, hafta, kinda, lotta, oughta, sorta, wanna, coulda, couldn've, couldna, woulda, wouldn've, wouldna, shoulda, shouldn've, or shouldna).

Transcribe all fillers, sounds that are not standard words but that do express some meaning. For example: hm, huh, mm, mhm, uh huh, um, mkay, yeah, yuhuh, nah huh, ugh, whoa, uh oh, ah, or ahah.

Transcribe repeated words or phrases.

> I went to the clinic to see, to see the nurse.

Transcribe truncated words (words that are cut off) as the audible sound followed by a hyphen.
For example:

> He wen- he went and did what I told him he shouldn've.

Unclear Speech
Indicate tape segments that are difficult to hear or understand on the transcript. For words or short sentences, use [inaudible segment]. For example:

> The process of 218 identifying missing words in a tape-recorded interview of poor quality is [inaudible segment].

For lengthy segments that are difficult to hear or understand, or when there is silence because no one is talking, record this information in square brackets. Also provide a time estimate for the information that could not be transcribed. For example:

> [Inaudible: 2 minutes of interview missing]

Overlapping Speech

Indicate overlapping speech (when multiple participants are speaking at the same time) that is difficult to separate and assign to individual speakers by typing [cross talk]. Resume transcription with the first speech that can be attributed to an individual.

Pauses

Mark brief pauses with periods or ellipses (. . .). Brief pauses are breaks in speech lasting two to three seconds. They often occur between statements or when the speaker trails off at the end of a statement. For example:

> Sometimes, a participant briefly loses . . . a train of thought or . . . pauses after making a poignant remark. Other times, they end their statements with a clause such as but then . . .

Mark pauses longer than 3 seconds by typing (long pause). For example:

> Sometimes the individual may require additional time to construct a response. (long pause) Other times, he or she is waiting for additional instructions or probes.

Questionable Accuracy

Indicate that a word or phrase may not be accurate by typing the questionable word between question marks and parentheses. For example:

> ##LL004_1## I went over to the ?(clinic)? to meet with the nurse to talk about joining up for the study.

Sensitive Information

When an individual uses his or her own name during the discussion, replace the name with the appropriate Participant ID. For example:

> ##LL008_2## My family always tells me, “LL008_2, think about things before you open your mouth.”
>
> #LL008_4## Hey LL008_2, don’t feel bad; I hear the same thing from mine all the time.

If an individual uses the names of people, locations, organizations, etc., identify them by typing an equal sign (=) immediately before and after the sensitive information. For example:

> ##LL001_1## We went over to = John Doe’s= house last night and we ended up going to = O’Malley’s Bar = over on =22nd Street= and spending the entire night talking about the very same thing.

Proofreading and Reviewing for Accuracy

Proofread (read through for errors) and check the accuracy of all transcripts against the audio-tape, then revise the transcript computer file accordingly. Check each transcript while listening to the tape three times before submitting it.

Check transcripts for accuracy. If the transcriptionist is not the same person who led the interview or focus group, then the interviewer or focus group moderator who did lead the session must also check every transcript for accuracy against the tape.

Removal of Sensitive Information

Replace sensitive information in the transcript with generic descriptive phrases enclosed within brackets. Sensitive information includes incidental mention of names of individuals, organizations, or locations that may compromise the identity of the participant or another person, such as a family member, friend, partner/spouse, coworker, doctor, study staff, clinic, hospital, social service agency, public figure, religious leader, entertainer, print media, restaurant, educational facility, or place of employment. The use of generic descriptions for names, places, groups, and organizations permits analysts to retain important contextual information while protecting the identity of the individual, place, or group.

Transcriptionists will have already identified sensitive information in the transcript by enclosing it within equal signs (=). To locate these easily, do a "search" for equal signs (=) in the text file. However, it is important for the interviewer or focus group moderator also to review the entire transcript in order to catch any sensitive information that the transcriptionist may have missed. For example:

[counselor's name omitted]
[name of local AIDS service organization omitted]

Appendix K

Mental Health Resources

American Counseling Association: Find a Counselor
https://www.counseling.org/aca-community/learn-about-counseling/what-is-counseling/find-a-counselor

Employee Assistance Program: Explore your company's EAP benefits for participating providers

HealthyWomen
https://www.healthywomen.org/your-health/how-partners-can-support-women-during-menopause

National Menopause Foundation
https://nationalmenopausefoundation.org/

National Suicide Hotline: Dial 988

Psychology Today: Find a Therapist
https://www.psychologytoday.com/ca/therapists/

U.S. Department of Health and Human Services, Office on Women's Health: Menopause Resources
https://www.womenshealth.gov/menopause/menopause-resources