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## **Changing Bodies: Experiences of Women who have Undergone a Surgically-Induced Menopause**

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## **Abstract**

We aimed to explore the lived experiences of women who had a surgical menopause as a result of undergoing a hysterectomy with bilateral salpingo-oophorectomy (BSO). We adopted a qualitative interview design using interpretative phenomenological analysis (IPA), and recruited seven women aged 47-59. We conducted synchronous online semi-structured interviews using the MSN (Microsoft Network) Messenger program. In the findings, we examine the prominent and under-researched theme of body image change. We discuss the women's journey from a deep internal bodily change, the meaning of this changing body image, through to the thoughts and behaviors involved with self-presentation concerns and coping with body image changes. A woman's perceived attractiveness and appearance investment are important factors to consider regarding adaptation to change over this transition. The findings might have implications for interventions designed to enhance mental well-being and increase health behaviors in women experiencing gynecological illness and/or menopause.

## **Keywords**

Body image; health and well-being; Interpretative Phenomenological Analysis (IPA); menopause; research, online;

Menopause is defined as the cessation of the menstrual cycle (World Health Organisation (WHO), 1996) and usually occurs in women between the ages of 45 to 55 (Williams, Levine, Kalilani, Lewis, & Clark, 2009). However, the overall transition from pre to post-menopause typically lasts four years and is often accompanied by symptoms such as hot flushes, redistribution of fat deposits, tiredness, memory loss and anxiety (National Institutes of Health (NIH) State-of-the-Science Panel, 2005). Although an entirely natural stage in the female aging process, the physical and psychological symptoms of the menopausal transition are often distressing, and associated with changed thinking about how the woman's body functions (Chrisler & Ghiz, 1993).

The natural menopause is a gradual process allowing the woman time to cope with bodily changes and their meanings, both in relation to their sense of self and within society. Nonetheless, one third of women aged above 65 will have undergone a hysterectomy because of gynecological illness or cancer risk (Torpy, Lynm, & Glass, 2004). Hysterectomy can not only reduce previous pain and risk, but also improve quality of life and mental health (Thakar et al., 2004). However, hysterectomy is often accompanied by a bilateral salpingo-oophorectomy (BSO), where the ovaries and fallopian tubes are also removed (Elson, 2005). A BSO results in an immediate surgically-induced menopause because of a dramatic reduction in sexual hormones, and the loss of childbearing capability (Wade, Pletsch, Morgan, & Menting, 2000). This can exaggerate and lengthen menopausal symptoms for as much as twenty years post-operation compared to those experiencing a natural transition (Fong, 2008). Adaptation to the sudden menopausal changes as a result of the BSO might be more difficult compared to the experience of a natural menopause because of greater feelings of distress, lowered self-esteem and impaired body image (Flory, Bissonnette, & Binik, 2005; Hickey, Ambekar, & Hammond, 2010).

For the purpose of this article, we refer to body image as the “multifaceted psychological experience of embodiment” (Cash, 2004, page 1), including feelings and thoughts about the body, and perceptions of appearance and the body’s functions and capabilities (Cash & Pruzinsky, 2002). People are embodied beings, and their health and emotions are expressed through their bodies (Fox, 1997). For the purpose of this article, we have used Merleau-Ponty’s (1962) definition of embodiment as the phenomenal body that is not just a physical entity, but how the individual person experiences their body. Thus, the body acts as a medium to our lived experiences and perceptions of the body (Leder, 1990).

It is not surprising, that the way in which people perceive their bodies and its functions are important to psychological well-being (Fox, 1997). More specifically, people need to continuously adapt to body image changes as a result of maturation, experience and mood. Most research on body image has been conducted with adolescents or young adults (Tiggemann, 2004) because physical development is considered to cease after the teenage years. However, the body continually changes until death and consequently it is important to investigate how adults adjust psychologically to changes in body shape, appearance and functioning (Cash & Pruzinsky, 2002).

Despite body image being a multi-dimensional construct, previous research on body image has tended to focus on perceived physical shape and appearance, largely to the exclusion of body image functioning (Hrabosky et al., 2009). Body image functioning refers to the perception and experience of bodily sensation (Johnston, Reilly, & Kremer, 2004). This might be a particularly important consideration when studying symptoms and aging across life transitions such as menopause, where bodily changes can be perceived as stressful burdens to an individual’s self-image.

Embedded within this potential burden on self-image is the influence of socio-cultural pressures on gender role expectation and a woman’s embodiment, and how this is then

translated into perceptions of the body and what it means to be a woman (Shilling, 2008). Raising feminist consciousness, authors, such as Bartky (1988) and Spitzack (1990) argued that a woman's body is always visible for judgment by others as a result of masculine constructions of femininity and internalizing their need for body control. This in turn, can increase body image problems and reduce psychological well-being, such as body objectification including body monitoring and shame (Fredrickson & Roberts, 1997).

Previous qualitative research investigating women's experiences of undergoing a hysterectomy, have tended to be discursive in nature and focus on decision making processes, cultural differences and social support (e.g., Galavotti & Richter, 2000; Lindberg & Nolan, 2001; Williams & Clark, 2000). Elson's (2005) qualitative research focused on a sociological perspective of gender identity with women who had undergone a hysterectomy, but highlighted the need to focus future exploration on the embodied experiences of appearance concerns and image management.

Fong (2008) used interpretative phenomenological analysis (IPA) to interview women with a high risk of ovarian cancer and examined their complex thoughts and feelings associated with the potential surgical removal of their healthy ovaries. Women expressed fears of the future unknown menopausal experience; the feeling of a separation of the self from the body, and the "transformation of their sense of health" and "personal agency" (page 14). Research is now needed to understand how women make sense of the bodily changes as a result of a surgical menopause, and how this in turn affects their thoughts, feelings and behaviors (Pearce, Thøgersen-Ntoumani, & Duda, in press). This information can provide guidance to health practitioners and help women make more informed choices in their healthcare decisions.

Our main purpose, therefore, was to explore the lived experiences of body image changes happening as a result of a surgical menopause in women who have undergone a

hysterectomy with BSO. In this study we aimed to retrospectively capture meanings associated with the participants' journeys through their menopausal transitions. This began prior to the hysterectomy, at which point the participants had not experienced menopausal symptoms and were thus considered pre-menopausal, through to their post-menopausal experiences following the hysterectomy.

It is difficult to judge and contrast experiences compared to a 'norm' and to other conditions because of the subjective nature of pain and symptomatology (Bury, 2001). Therefore, we took an idiographic approach in seeking to explore the meanings the women associated with their experiences. We took the position that they, not the researchers, were the expert of their own experiences. We, therefore, adopted an IPA approach because it prioritizes the role of an individual's beliefs and the interaction with their embodied experiences (Dickson, Knussen, & Flowers, 2008).

## **Methods**

The use of an IPA approach (Smith, 1996) in this research provided the conceptual background and guided the qualitative processes of this study. The major goal when using IPA is to elaborate a "rich and contextually grounded understanding of a phenomenon" (Darker, Larkin, & French, 2007, page 2174) based on how people make sense of their experiences, and was therefore well suited to our aims within this study.

Prior to the main IPA study, a face-to-face focus group interview with five women experiencing the menopausal transition was carried out by Gemma Pearce. Our aim in this interview was to discuss the utility of potential feasible methods for this study. The idea of menopause as a sensitive and personal taboo subject was a dominant issue. Several women in the focus group expressed that "some women experiencing menopause" might not feel comfortable opening up to someone younger than themselves who has not experienced the transition.

The women in the focus group discussed the potential biases and difficulties of collecting rich and honest accounts from future participants because Gemma Pearce, who was carrying out the interviews, was a 27 year old woman. With this in mind, an innovative online interview method was employed using MSN (Microsoft Network) Messenger software (Pearce, Thøgersen-Ntoumani, & Duda, 2009; Pearce, Thøgersen-Ntoumani, Duda & McKenna, 2011).

A text-based Instant Messaging (text-IM) method was implemented because it complemented the aims of the research. This synchronous online method of interviewing provided a continuity of discussion not accomplished in alternative text-based interviewing tools, such as open-ended questionnaires, email and discussion boards. We developed the text-IM to encourage an extra level of anonymity between the researcher and the participant that cannot be achieved in face-to-face interviews (for further discussion on this see Pearce, Thøgersen-Ntoumani, & Duda, 2013; Jowett, Peel, & Shaw, 2011).

### *Sample*

We recruited seven women born between 1950 and 1962. The size of the sample and its homogeneity meet recommendations for IPA and emphasizes its commitment to ideography (Hefferon & Gil-Rodriguez, 2011) on two grounds; (a) it allows an in-depth phenomenological inquiry and (b) it overcomes the potential risk of losing subtle meaning by using larger data sets (Reid, Flowers, & Larkin, 2005).<sup>1</sup>

We distributed community advertisements across England in places such as petrol stations, shops, educational institutes, theatres, public houses, and community and leisure centers. The only establishments where we were denied permission was in some large shopping mall toilets where people pay for advertising. We specifically targeted areas where we thought women experiencing menopause might frequent, such as in a theatre in London

that hosted a play about the menopausal transition. The posters had pull-off tags detailing Gemma Pearce's contact details.

The most successful placing of the posters was in women's public toilets on the inside door of individual stalls. This was possibly because no one else saw the woman take a tag, thus increasing their confidentiality. To ensure adequate contextualization (Smith, 2008), the recruited sample was screened on a purposive basis to ensure homogeneity. All included participants had undergone a surgical menopause (total hysterectomy with BSO) because of a medical condition and were pre-menopausal prior to the operation. All participants described themselves as White, living in the United Kingdom and having children (two also had grandchildren).

The participant's ages ranged from 36 to 54 years old at the time of the interview and ranged from six months to nineteen years post-operation. All of the hysterectomies were for medical reasons, one case of endometrial cancer and the remaining six because of benign conditions, such as fibroids or endometriosis. Three participants reported having no menopausal symptoms after the surgery, two of whom had taken HRT since the operation, one had not. Out of the remaining four, two experienced menopausal symptoms straight after surgery, one experienced them six months after surgery and one a 'few years' after surgery.

All of those latter four participants had undergone HRT straight after their hysterectomies but stopped taking it because of a variety of reasons: one after six months because of unpleasant symptoms and concerns of breast cancer, one after five years because of doctors' recommendations, one after seven years because of concerns of deep vein thrombosis, and one after eight years because of abnormally elevated estrogen levels. The latter two participants were diagnosed with breast cancer one to three years after the cessation of HRT. They both believed their breast cancer was linked to HRT but this had not been medically confirmed.

## *Procedure*

We provided an information sheet to participants, along with the opportunity to discuss any queries with the researcher throughout all stages of the research process. Participants completed a consent form before participating in the one-to-one online interview with Gemma Pearce. Participant confidentiality and anonymity were ensured and the study was approved by the ethics committee of the University of Birmingham in the United Kingdom. Participants were informed of their right to withdraw from the study and that they did not have to answer any questions that made them feel uncomfortable. A new, dedicated research MSN account was set up to avoid the need for participants to use their personal accounts. Participants were provided with a unique username and a login password to ensure anonymity. Data were collected retrospectively and transcribed using MSN Messenger software.

The interview schedule was semi-structured comprising open-ended questions focusing on the uniqueness of each woman's lived experiences from before to after the hysterectomy. Consistent with IPA, the interview schedule outlined the areas of interest but was not prescriptive, thus permitting iterative exploration of the topics that emerged. The interview started with broad general questions, such as "Please can you tell me about your experience of the hysterectomy?", "How do you feel about your health over this transition?" and "What would you recommend for women who might be in a similar situation in the future?" Prompts were used to explore emergent topics, such as "How did that make you feel?" and "How did you deal with that?" This allowed the participant to set the parameters of the topic so that the researcher did not impose their understanding of the phenomenon on the participant's narrative (Smith et al., 2009). Interviews lasted for between ninety minutes and two hours.

## *Analysis*

An in-depth examination of each transcript was completed using IPA; for further information of the coding and thematic generation procedures see Smith (2003). Two stages of interpretation (double hermeneutics) were adopted during the analysis process (Larkin, Watts, & Clifton, 2006). The first was the appraised meaning provided by the participants and the second by the researchers applying their understanding of each participant's account (Smith, 2008). Thus, the findings are a representation of both the participants' and researchers' communication and interpreted understanding throughout the interview process.

To improve trustworthiness, we employed validity procedures via a process of analytic audit and researcher triangulation (Smith, 2004). The texts and their emerging themes were reviewed by the four authors, each with varying levels of immersion in the study and all with backgrounds in Sport, Exercise and Health Psychology. Consistent with personal reflexivity all authors aimed to understand each participant's experience, avoid deductive judgments and reflect on their personal involvement and influence in the study (Nightingale & Cromby, 1999). Gemma Pearce carried out the interviews, conducted the detailed coding and development of themes, and completed the interpretative process through the writing of the article. The other three authors contributed to the development and structure of the themes and this article, drawing retrospectively on their informed positions of the research topic. All disagreements were discussed and resolved. This reflection aided the abstraction of themes and the final writing stage of the IPA.<sup>2</sup>

## **Results**

Our aim, while using IPA, was to address both convergence and divergence within a group's experience, and therefore comparisons were made at an individual level (Smith et al., 2009). This rich data set yielded many striking stories covering aspects such as support and relationships; identity, gender, sex; and other large concurrent life changes (e.g., children leaving home, divorce or ill parent). However, bodily change was a prominent theme arising

in all of the interviews and is an area lacking research and practical understanding; therefore we choose it as the focus of this article. The women's perceptions of their bodies over this transition seemed to shape the similarities and differences in their lived experiences.

The journey for the women in this article began with a deep internal feeling of bodily change, often from wellness to illness. In the first theme, we address this visceral sense of change to the body's feelings and functions. In the second theme, we discuss the meaning of the changing body to the women, and how they reflected on a changing body image. In the third and last theme, we examine the changes of the externally judged body. We discuss the use of the methods used to cope with the changes and threats to their body image and self-presentation.

### *The Internal Body*

This theme arose because of the personal individual change each woman felt. The women often discussed the body as a material entity that was no longer functioning in the way that felt normal to them. Thus, they thought that they no longer lived in a well body. The women used phrases such as "I knew something was wrong" and "I felt unwell. I knew I could not carry on with the way things were." This started at the time of the gynecological illness that led to the hysterectomy. The majority of women felt pain or an obvious physical symptom, such as heavy bleeding, which led them to seek medical advice. One woman was an exception to this because she did not suffer pain as a result of her gynecological illness. However, she had been visiting the hospital regularly for nine years with problems conceiving because of endometriosis and for medical screening purposes because her mother had died from ovarian cancer, and therefore thought a great degree of threat from a potential surgical menopause. Fundamentally, all of the women's journeys over this transition began with an internal bodily change that indicated malfunctioning and ill-being.

Leder's (1990) philosophy of dysappearance is defined as the appearance of a dysfunctional body into consciousness. This was not only reflected in the women's experience of symptoms, but the overall awareness of negative bodily change, which emanates from the gynecological illness, the hysterectomy with BSO and the resulting menopause. The women's experiences of dysappearance varied at this point depending on their menopausal symptoms and HRT choices. Two women were very good examples of the convergence and divergence within this theme. Both had exploratory surgery with the possibility of a hysterectomy and both woke up to be told they had not only had a total hysterectomy, but a BSO, and had therefore become menopausal.

The dysfunction of the physical body was viewed as something that the women did not have control over. However, the divergence between the women was apparent regarding their individual interpretation of this feeling and their perception of control over actions that could be taken in response. One of the women had requested a hysterectomy in the first place and perceived the additional need for the BSO as "justification for asking for the operation and confirmed that [she] had not been imagining things." Alternatively, the other woman thought that the result of her exploratory surgery was a "shock to the system" where the "body is not adjusting a bit at a time," and therefore she was "hoping for a magic cure" for menopause.

Unlike the former, the second woman did not use language that showed she thought in control of her body and its functions. She wanted her body to feel "normal" again (in the sense of wellness, as opposed to a social norm) and thought that she was waiting for someone else to explain what the "problem" was and how to make it "better." The need to feel in control of the body during this transition was an important consideration for all of the women.

A fourth woman ended her interview with this apt summary of her positive attitude and feelings of control.

Of course being diagnosed with cancer, and still having to have check-ups is a bit tedious, but at the moment I feel fine, healthy, and well, so it is *carpe diem* and live in the moment, it reminds me of that old Frank Sinatra song - *My Way* (Sinatra, F., 1969).

Stephen's (2001) qualitative study investigating the natural menopause found similar examples of visceral and experiential embodiment. However, in contrast to the gradual adjustment associated with a natural menopause, this highlights the "instant" bodily change induced by the surgery. This bodily transition is not just based on simple trends of change, but of complexity differing on the individual's understanding, meaning and perceived control.

### *The Meaning of Bodily Change*

The hysterectomy symbolized the entering of a new stage of life, for example "it just means you're going from one phase in your life to another." However, the changes in perceptions of body image did not follow a simple positive or negative experience but were drenched in complexity. Prior to surgery, the women expressed similar concerns about the function of their bodies. They thought they were constantly waiting for their bodies to "malfunction" and their lives were disrupted by hospital visits, or painful and embarrassing symptoms. "I felt at the mercy of my body." This lived experience of the changing body impacted on the women's perceptions of their appearance and threatened their body image.

After the surgery, all participants expressed relief from worry about "female bodily constraints" because none of the women now had to worry about a menstrual cycle or birth control. However, a noticeable divergence in participants' body image after the surgery was apparent depending on whether or not they experienced menopausal symptoms and perceived

these as a threat to their body image. Not only were there individual differences, but the women experienced daily fluctuations in body image states as well, for example “if I feel fat I feel rubbish. If I feel my body image is good then I feel good.”

Another woman expressed an improvement in most areas of her life, including body image, after the surgery. However, she experienced a “sad feeling with the finality of not being able to have another child.” This embodied experience negatively changed her perception of herself as a sexual being (Merleau-Ponty, 1962). This seemed to manifest itself in her body image, which impacted on her relationship with her husband. She said “all I had inside me was a black hole that made me feel strange” and she believed this stopped her from wanting to “make love.” She expressed one of the most prominent explanations of meaning, “all of your other bodily changes signify expectancy (puberty/pregnancy) whereas menopause signals a closing down of purpose.”

One woman told the story of her friend who “would not feel like a woman if her periods stopped.” She reflected on her friend's experience saying.

Some women's sense of selfhood depends on this aspect, but not for me. I can be myself again because I am freer, and that in turn is liberating. I do not feel the same as I did before, I feel better.

These rich interviews highlighted the important complexity of experience that is often missed in quantitative studies. Not all transitions are experienced as either negative or positive, but might be experienced as both depending on the meaning attributed to the (changing) body.

For the women who experienced the “female trials” of HRT and menopausal symptoms after surgery, a new set of threats encroached on the women's body image, such as increased weight, changes in body shape, and feelings of embarrassment and ill-being because of hot flushes, “it makes me feel awful, depressed, fed up, frumpy - before I was

really petit, skinny and energetic.” These participants expressed feelings of distress because their pre-hysterectomy suffering had not been “solved” but merely changed.

This was particularly the case for the first participant discussed who had not felt symptoms as a result of her gynecological illness but did experience menopausal symptoms after her operation. She felt “unwell” and the principal concerns she discussed included feeling older and the negative perceptions of her body shape, breast size, and weight changes.

I gained about half a stone after the op[eration] and developed a big stomach, I think for my size. I do not like the look of it because I am small everywhere else.

Everyone seems to think I am making a fuss, because I guess I am still on the small side compared to some.

She expressed a conflict between her own negative perception of the bodily changes, and other peoples’ more positive perceptions of her body. Even though she acknowledged others having a positive perception of her body, she was still concerned about how she would feel about displaying her body in front of others. “I feel disappointed. I had not expected to ever be concerned over my size.” She also discussed how taking HRT to reduce her symptoms had increased her feelings of attractiveness through “bigger boobs” while coming off of HRT meant a loss of the breast size, which was a downfall. She explained that because she had always perceived herself to be attractive, she believed that her self-worth was highly contingent on appearance. Therefore, bodily changes caused a high threat to her body image and increased her self-presentation concerns (Leary, 1995). Her increased shame and monitoring of her bodily changes, with a focus on appearance to the exclusion of other activities suggests high levels of self-objectification (Fredrickson & Roberts, 1997).

### *The Externally Judged Body*

Through these interviews, it became clear that the bodily changes were not just internally felt. There were profound personal meanings associated with having a surgical menopause that

were also manifested externally. These issues extended to how the women thought other people perceived them, how concerned they were by this, and how they coped with positive and negative changes to their body image.

Participants discussed coping with threats to their body image both before the hysterectomy as a result of their gynecological illness and after the hysterectomy as a result of menopausal symptoms. One woman, for example, dealt with body image threats by “laughing it off” and “not dwelling on it.” Additionally she sometimes used psychological avoidance (Cash, Santos, & Williams, 2005) or denial (Lazarus, 1993) to cope with body image threats, “it is almost as if I had decided that I was not going to acknowledge that this was happening to me.” As a consequence, she did not confide in other people. In contrast, and notwithstanding that, another woman also said that she “just put up with it.” She found it useful to “turn to others for support from partners, friends and other women with similar experiences.” She expressed the importance of “knowing you are not the only one.” All participants compared themselves to others to help them to put their experiences into perspective.

All of the women discussed their attempt to change their appearance to cope with the perceived threats to their body image. They reported “dressing down to hide in the crowd,” wearing clothes that displayed less of their bodies in public, using appetite suppressants or physical activity to control weight and appearance, or alternatively avoiding physical activity when such situations exacerbated their negative body image (e.g., embarrassing hot flashes or heavy bleeding). Alternatively, the women who did not experience menopausal symptoms after the hysterectomy, either with or without HRT, expressed feelings of liberation and attractiveness. This was often because of the relief from having either a lack of symptoms or not experiencing body image threats. In addition, these women discussed the motivation to reinvest in their appearance. One woman was a prime example of this. When experiencing

her gynecological illness she “did not want people to look” at her. After the operation she felt “younger, with a sense of new life.” “I seem to want to take better care of my skin. I have changed the way I wear make-up. I think it is because I feel reborn; different clothes.”

Some participants, however, were more dependent on other people’s opinions of their appearance, rather than how they felt in their own bodies, especially as they grew older. “I think someone complementing your appearance makes you feel positive. You tend to become less visible as you become mature.” This corroborates Fredrickson and Roberts’ (1997) theory that a woman’s body will become less sexually objectified as they become older and therefore relatively invisible. However, this exchange between the attention of being judged for the feeling of being invisible might explain why body dissatisfaction remains stable (Tiggemann, 2004).

The link between symptoms, energy levels and body image was also reflected in the motivation to re-engage in physical activity after the surgery. Two women both “resented” the gynecological illness prior to the operation with specific reference to its disruption to their ability to exercise. One of the two women explained, “I have never liked being unfit. I felt like a fat lump and I resented not being able to spend so much time with my friends as I felt left out to a certain degree.” The other woman explained how “flooding” (heavy menstrual cycle) as a result of her gynecological illness stopped her from playing tennis. She was concerned about it happening while she was playing. She was happy that after the hysterectomy she was able to play tennis again.

As soon as they had the operation these women felt energetic, wanted to take up exercise again and as a result felt more positive about their social lives and body image. The former woman said.

As soon as I had the operation I felt free and could get on with life - back to my sports, playing with the children, not worrying about what I was wearing and for quite a while I felt amazingly energetic.

This supports the discussion by Deeks and McCabe (2001) on the potential importance of symptoms and their impact on vitality levels, physical activity and health.

All of the women discussed trying to think and behave rationally and/or positively as a means of coping. This included improvements to the management of their health, and expressing the acceptance of this change. Some achieved this by focusing on a potentially better future, accepting that symptoms were beyond their control and/or comparing themselves with other women who were “worse off” to help themselves to feel better about their bodies.

Taking a proactive approach to the management of symptoms seemed to help them to better understand their transition, body and how to cope adaptively. For example, one woman felt well informed about the changes her body faced and she recommended to other women experiencing gynaecological illness and/or menopause should deal with one symptom at a time and “find out what works for you.” Some discussed reducing the importance of appearance as they got older. This process might partly explain Tiggemann’s (2004) findings that body dissatisfaction seemed to remain stable throughout the lifespan. Most important perhaps, some women started to redefine their own criteria of physical attractiveness. Thus, weight became less important and factors such as not looking tired or run down became more pertinent.

## **Discussion**

The experience of having a hysterectomy with BSO, and menopause it inevitably induced, resulted in bodily changes in appearance and function that often influenced an individual’s body image experiences, psychological wellbeing and health-related behavior.

The emerging themes illustrate the similarities and heterogeneity in body image experiences of women who have experienced gynecological illness and a surgical menopause. We have highlighted the journey of disappearance: the experience from changes in deep visceral bodily feelings and functions (Leder, 1990); to what these bodily changes mean to the individual, for example in relation to female identity and aging; to the externalization and management of these body image improvements and threats.

In concordance with the findings of Deeks and McCabe (2001), some participants perceived negative changes to their body image. These participants often experienced low feelings of control over their bodies, yet they also felt it was important to self-present as attractive individuals. However, the opposite pattern was evident in other women who experienced a positive transition with fewer body image threats despite undergoing similar bodily changes. In fact, some women experienced a range of positive and negative body image changes simultaneously. Our results highlight the importance of using a tailored approach in interventions designed to increase wellbeing in women who have had a hysterectomy with BSO.

Going beyond the descriptive trajectories of change, the different experiences appeared to be a result of not only intensity of gynecological and menopausal symptoms, but also a result of subjective vitality and differences in appearance investment between individuals. This study is the first examining the important impact that gynecological and menopausal symptoms can have on vitality levels, body image, physical activity levels and wellbeing, which all appear inextricably linked. Further investigation is now needed to investigate symptoms over the menopausal transition and their link with vitality levels, to see if low vitality acts as a barrier to physical activity. Evidence has shown that exercise reduces vasomotor menopausal symptoms and improves quality of life (Daley, Stokes-Lampard, &

Macarthur, 2009), and therefore this symptom-induced lack of energy is an important barrier to overcome and for health practitioners to consider.

Previous literature examining coping and menopause, has mainly focused on methods women use to deal with symptoms, such as management of hot flushes and sleep disruption. There is a dearth of research on how individuals perceive and cope with threats to their body image with the extant literature only focusing on young adults (Cash et al., 2005). Three main dimensions emerged from the research of Cash, et al. (2005): avoidance, appearance fixing and positive rational acceptance. Avoidance (or denial; Lazarus, 1993) represents an individual's attempts to evade threats to thoughts and feelings about the body. Appearance fixing involves attempting to change appearance by concealing, camouflaging, or fixing a physical characteristic perceived as problematic. Positive rational acceptance, refers to strategies which focus on positive self-management, such as engaging in physical activity, rational self-talk and acceptance. Whereas the first two dimensions represent more dysfunctional methods of coping, the third illustrates a more adaptive transformational strategy.

No previous research has specifically investigated coping with body image concerns in women who have experienced gynecological illness, hysterectomy with BSO or menopause. Our findings not only corroborate the dimensions of coping introduced by Cash et al. (2005) when investigating young adults (18-29 year olds), but they also add population-specific and contextual detail to the dimensions. This includes the change in importance placed on appearance and a reassessment of the criteria for attractiveness. This new information on adaptive coping methods for body image, symptoms and aging can help inform and improve future applied practice and design of interventions.

It is clear from our findings that there is a lack of support, education and care available to the women experiencing this transition. Health practitioners can use the positive

and successful experiences against the negative and distressful stories from this article to inform future practice. It seems that self-management<sup>3</sup> of gynaecological illness and a surgically-induced menopause provides an adaptive and empowering transition for these women. This included knowledge and acceptance of the condition and the body, maintaining or taking up healthy behaviors, peer support, and feeling autonomous over your life, body and condition. We recommend this patient-centred autonomy supportive approach be used in future healthcare to facilitate and support women to self-manage these bodily changes.

Our findings support and add to the research examining body image in middle-aged adults (Tiggemann, 2004) and provide new information to researchers and practitioners regarding the lived experiences of women who have undergone a surgical menopause. This includes women's perceived changes in body image threats, the methods they used to cope with them, and their reasons for using these methods. This experience of gynecological illness, hysterectomy with BSO, and the menopausal transition was interpreted as negative, positive or a mixture of both simultaneously by the women in this study. It is important to understand more about the factors that influence these interpretations to improve a woman's quality of life during this period. In addition to examining the menopausal transition, it is important to assess changes in experiences related to other life transitions (e.g., pregnancy, general aging) because the body image issues pertaining to such transitions are likely to be different.

Our findings are in concordance with previous research highlighting the generally negative consequences of menopause in relation to health behaviors (Elavsky & McAuley, 2005). Our current findings also emphasize the importance of changing symptoms resulting in changes to all body image dimensions, including both appearance and functioning, and consequent changes in health behaviors. Our research accentuates the changeability of symptoms, body image, affect and behavior. Future research could adopt diary methodologies

(for example, Miklaucich, 1998) to explore the dynamics and interplay of menopausal symptoms and body image states with engagement in health behaviors.

### *Methodological Reflections*

Our findings highlight the importance of examining changes over prominent stages of life. However, a limitation to the design in this study is that data were retrospectively collected, thus relying on the recall of each participant regarding the entire transition. Although people are likely to remember the peak and troughs, the emotionally salient events might be skewed by memory (Dickson et al., 2008). Furthermore, because of the idiographic nature of this research, these research findings are specific to this group of people and cannot be generalized to a wider population. We recommend that in the future, researchers use a longitudinal qualitative design to gather accounts over the course of the transition and explore how experiences change over time.

The majority of participants found the text-IM interview a convenient, flexible and encouraging environment. Unfortunately some women chose not to participate because of a lack of familiarity with technology or the absence of body language, tone of voice and facial expressions. Therefore, even though a purposive sample was chosen for this study, it should be acknowledged that participants also consisted of those that were comfortable participating in the online interviews.

It is also important to acknowledge that by using a different communication method, a different type of relationship between the participant and researcher is created. Different communication methods might benefit different types of people and preference might depend on the subject and situation. This can be overcome in future by offering a range of interview methods to the participants. However, the text-IM interviewing tool alone might be the most suitable tool when exploring sensitive topics, when aiming to reduce researcher bias or when

extra participant anonymity is appropriate (for a full evaluation of this method from the participants' and researchers' perspectives, see Pearce et al., 2013).

We thought it was important to ask the participants for their recommendations to women who will undergo a hysterectomy with BSO in the future. Reflection on their answers helped the researchers to make sense of the interviews and reach conclusions in relation to future recommendations for researchers and practitioners. However, we acknowledge that all investigators in this study had a Sport, Exercise and Health Psychology background and the interpretations should be seen in this light. This limitation can be overcome in future collaborations using researchers with more diverse academic backgrounds.

The methods and findings we have adopted in this study strongly build on previous literature in multiple ways. It is the first study to: (a) use and reflect on a text-based online interviewing method with women who have experienced a surgically-induced menopause; (b) examine the important impact that gynecological and menopausal symptoms can have on vitality levels, body image, physical activity levels and wellbeing; (c) build on previous literature on coping with menopause. Previous literature focuses on methods to manage symptoms physically, such as wearing layers of clothes to cope with hot flushes. In this study, we uniquely examine coping with body image concerns; and (d) build on previous findings of coping with body image concerns by examining these issues with an underserved group of women, adding population-specific and contextual detail to the dimensions. This includes the change in importance placed on appearance and a reassessment of the criteria for attractiveness. This new information on adaptive coping methods for body image, symptoms and aging can help inform and improve future applied practice and design of interventions.

*Conclusion*

The changing nature of body image experiences was evident in the women's accounts of the menopausal transition. From our findings we also suggested that the meaning of the body, perceived attractiveness, appearance investment and self-presentation concerns might affect adaptation to, and coping with, bodily changes. Methods that menopausal women use to cope with body image threats were identified in this study, such as avoidance of presenting themselves in public when feeling ill or low, reassessment of their criteria of attractiveness, and self-management. Our findings might have important implications for the wellbeing of menopausal women and can be used to inform future practice and interventions designed to enhance mental wellbeing and optimize health behaviors in this population.

## Notes

<sup>1</sup> We did not aim to achieve saturation, because this is a criterion appropriate to grounded theory (Glaser & Strauss, 1967), but does not fit with the idiographic philosophy of IPA (Shaw, 2011).

<sup>2</sup> The philosophy of IPA is heavily rooted in Heidegger's (1962) idea that the interpretations of the participant and the researcher cannot be separated from the lived experience. These interpretations are therefore critical to the rich analysis in IPA. Therefore, the technique of bracketing was not used in this article because this is consistent with Husserl's (1962) contradicting phenomenological approach.

<sup>3</sup> We refer to the holistic definition of self-management proposed by the Department of Health (2001) that focuses not just on medical management, but also on psychological, emotional, social and spiritual aspects of quality of life. "Developing the confidence and motivation of patients to use their own skills and knowledge to take effective control over their lives and not simply about educating or instructing patients about their condition" (page 6).

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