Place-Based Experiences in the Work Environment During the Menopausal Transition: A Case Study of Canadian Physiotherapists

by

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Author's Declaration

I hereby declare that I am the sole author of this thesis.

This is a true copy of the thesis, including any required final revisions,

as accepted by my examiners.

I understand that my thesis may be made electronically available to the public.

Abstract

Background: The global workforce is aging, with increasing numbers of employees experiencing the transition to menopause. This transition to menopause, known as perimenopause, involves hormonal changes with secondary symptoms impacting individuals at various degrees, times, and intensities. Menopause marks the end of the menstrual cycle, although the transition can last from 7 to 14 years. In the work environment, menopause is often a taboo topic. However, the 2021 Global Consensus Statement on Menopause in the Workplace from the European Menopause and Andropause Society recognized the individual experience(s) of menopause and the relationship of this experience within the work environment. In addition, new research suggests that the work environment affects the experience of menopause, and the embedded physical, psychosocial, and cultural factors are critical to understand and explore when creating inclusive work environments. Continued investigation is critical to ensure institutions are knowledgeable and aware of structures necessary for the increasing number of menopausal employees.

Objectives: While the literature on menopause enhances our understanding of health issues (e.g., osteoporosis, cancer, cardiovascular disease), these findings remain descriptive, biomedical, lacking theoretical frameworks, and void of the lived experience. This research focused on increasing our understanding of the gendered dimensions of health and wellbeing concerning the transition to menopause within the work environment, using a case study of Canadian physiotherapists. Specifically, the research explored the following question: How do place-based experiences in the work environment impact physiotherapists undergoing the transition to menopause? In addition, the research addressed the following objectives: 1) To examine the relationships between aging, gender, health, and wellbeing in the workplace, 2) To explore the

experiences of perimenopause for physiotherapists in the Canadian work environment, and 3) To document the perceptions of existing structural support(s) in the workplace shaping physiotherapist's experiences with the menopausal transition.

Methodology: Stake's approach to qualitative case study research guided this work. Feminist geography provided the theoretical perspective to shed light on how relations of power and inequality over the life course shape health and wellbeing as part of aging. Examining life course experiences further exposes how gendered relations of power and inequalities experienced over time shaped experiences of wellbeing as part of aging and the menopausal transition. In-depth interviews with 29 participants were audio-recorded and transcribed verbatim for subsequent analysis in NVivo. Data analysis used Braun and Clarke's reflexive thematic analysis approach.

Findings: Three main themes emerged; 1) Exploring Being Well at Work, 2) The Embodied Experience, and 3) Navigating Supports. In keeping with feminist geography, these themes and sub-themes were developed by understanding power and exploring the intersections of identity, knowledge, and agency as they relate to health and wellbeing.

Discussion and Implications: Through the engagement with physical bodies, physiotherapists provide health care to improve the mobility and wellbeing of patients. In this context, the menopausal body is problematic as the physiotherapist must conform to being strong and manage the complex clinical environment. Negotiating the experiences of perimenopause in the work environment requires attention to both individual characteristics and institutional context. While menopause continues to be unrecognized and unaddressed within work environments, an embodied approach that attends to the biomedical perspective and the lived experience may normalize the menopausal experience at work.

This research makes three contributions. First, to understand workplace experiences of perimenopause and how aspects of work can intensify these experiences through health geography. Second, recognizing 'age' as another structure of power that organizes society and informs group identities within feminist geography. Third, by demonstrating the need for supportive and inclusive organizational culture(s) in the workplace.

Conclusion: The findings of this research have implications for physiotherapists and other health care providers. Health care teams knowledgeable about menopause create confidence to offer support to themselves, their team, and their patients. The participants recommended education, practice and policy interventions in the workplace that include demystifying menopause through education, supporting flexibility, and focusing on wellbeing, not only health.

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Dedication

"Bowing to the intelligence of the mind, and the wisdom of the heart"

I dedicate this work to my mom, Fran,

for reminding me of the importance of education

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CAPR	Canadian Alliance of Physiotherapy Regulators
CIHI	Canadian Institute for Health Information
CPA	Canadian Physiotherapy Association
CCPUP	Canadian Council of Physiotherapy University Programs
EMAS	European Menopause and Andropause Society
FMP	Final Menstrual Period
IMS	International Menopause Society
NAMS	North American Menopause Society
NPAG	National Physiotherapy Advisory Group
PEAC	Physiotherapy Education Accreditation Canada
SOGC	Society of Obstetricians and Gynecologists of Canada
STRAW	Stages of Reproductive Aging Workshop
WCPT	World Confederation of Physiotherapy
WHI	Women's Health Initiative
WHO	World Health Organization

Chapter One: Introduction

1.1 Chapter Outline

This chapter introduces the dissertation, which explores the menopausal transition in the workplace, specifically in the Canadian health sector. The chapter begins with the rationale for this research, the theoretical framework, and the background of the case study. The following section highlights the research question and objectives concluding with an overview of the dissertation structure.

1.2 Background and Rationale

This research focused on increasing our understanding of the gendered dimensions of health and wellbeing during the transition to menopause within the work environment. To date, limited research explores the gendered experience of transitioning into menopause in the workplace (Verdonk et al., 2022). This research used a case study of Canadian physiotherapists.

As the global workforce is aging (Wisseman et al., 2022), there is a shift in the demographic makeup of the workforce that requires a reassessment of human resource support and policies (Ince, 2022). Recent employment data shows an increasing number of women aged 45 and over in the workforce (Hennekam & Dumazert, 2021; Stats Canada, 2019), and this age group corresponds to the average age of the reproductive cycle known as perimenopause or the transition to menopause (Jane & Davis, 2014). The menopausal transition involves hormonal changes with secondary symptoms impacting individuals at various degrees, times, and intensities (Zhu et al., 2022). Menopause marks the end of the menstrual cycle, represented by reduced estrogen and progesterone production (El Khoudary et al., 2019), with the average age of menopause being 55 (SOGC, 2019). However, the transition to menopause can last from 7 to 14 years (Chichester et al., 2011; Bellipanni et al., 2005) before the last menstrual period.

While these physiological changes are a normal part of aging, research has primarily focused on this aspect of transition (Dutton & Rymer, 2020) with little emphasis on the social and psychological experiences (Suss & Ehlert, 2020; Bhakta et al., 2018). Learning to adapt to the physiological changes in the body can be challenging. At the same time, perimenopausal individuals must also accept an end to their fertility (Harper et al., 2022), find new meaning in their identity (Dillaway, 2020), and redefine their roles at this stage of life (Dillaway & Wershle, 2021).

Popular culture presents menopause as a biological event (Merrill, 2019) in which the physical body fails (Atkinson et al., 2021). By presenting menopause as an issue, scholarly dialogue has primarily focused on fixing the problem and identifying treatment(s) (Krajewski, 2019) rather than learning about individual experiences (Dillaway, 2020). Research that explores the ability to adapt to this new phase of life will assist our understanding of how individuals participate and contribute to society throughout the transition.

Many individuals undergoing the menopausal transition are employed and negotiating their symptoms in a work environment (Jack et al., 2021). This research aims to contribute to the scholarly literature by understanding the sociocultural and individual experience of the transition to menopause in the workplace.

In the work environment, menopause is often a taboo topic (Atkinson et al., 2021). However, academia, policymakers, and employers are recently paying attention to menopause in the work environment (Targett & Beck, 2022). For example, the 2021 Global Consensus Statement on Menopause in the Workplace from the European Menopause and Andropause Society (EMAS) opened the doors and conversation about menopause in the workplace (Jack et al., 2021). This Statement was significant as it recognized the individual experience(s) of

menopause and the relationship of this experience within the work environment (Jack et al., 2021). In addition, new research suggests that the work environment affects the experience of menopause, and the embedded physical, psychosocial, and cultural factors are critical to understand and explore when creating inclusive spaces at work (Jack et al., 2019; Bariola et al., 2017; Griffiths et al., 2013). As such, continued investigation of building evidence is critical to ensure institutions are knowledgeable and aware of support structures for the increasing number of menopausal employees (Hardy et al., 2018).

1.3 Theoretical Framework

Menopause has been conceived as a pathological condition and, therefore, often medicalized by healthcare providers (Backonja et al., 2021). Although the empirical literature on menopause enhances our understanding of health issues (e.g., osteoporosis, cancer, cardiovascular disease) (El Khoudary, 2020; Fistarol et al., 2019; Dunneram et al., 2019), these findings remain descriptive, biomedical, lacking theoretical frameworks, and void of the lived experience.

Social theory helps to generalize knowledge, develop critical reflection, and complement biomedical, epidemiology and health services work (Herrick, 2016). A more thorough consideration of theoretical applications is needed to better understand the experiences of perimenopause across the life course (Atkinson et al., 2021; DeLyser & Shaw, 2013). Health geographers can contribute to these discussions by using theory to understand population distributions of health, disease, and health care and propose explanations of underlying causes or influences of observed phenomena (Gatrell & Elliott, 2015; Luginaah & Bezner-Kerr, 2015). This research enhances knowledge of perimenopause grounded in a theoretically informed framework and embedded in health geography.

This research used feminist geography as the theoretical framework to investigate the menopausal transition. Drawing on feminist geography sheds light on how relations of power and inequality over the life course shape health and wellbeing as part of aging (Domosh, 2001, 1998). Examining life course experiences over time further exposes how gendered relations of power and inequalities shaped wellbeing experiences as part of aging and the menopausal transition (Finlay, 2021). This research, guided by feminist geography, explores the co-existence of identities as part of health and wellbeing for persons experiencing menopause in the workplace (Mollett & Faria, 2013). Additionally, this research examines gender through other axes of power and diversity, such as race, sexuality, class, age, and place (Crenshaw, 1989; Mollett & Faria, 2013; Nightingale, 2006).

1.4 Case Study

A case study aims to develop an in-depth understanding of a case (Baxter & Jack, 2008; Stake, 1995) and provides the framework for researchers who seek answers to "how" and "why" questions (Baxter & Jack, 2008; Stake, 1995; Yin, 2009). A case study approach leads to findings that inform a deeper understanding of the topic and explore phenomena with little information and knowledge (Gerring, 2004). This research used a case study approach, given the lack of knowledge on menopause in the workplace.

Guided by Stake's instrumental case study approach (Stake, 1995), the research seeks to understand a specific case to assist in developing a general understanding of a phenomenon. Therefore, an in-depth case study aims to improve the understanding of the phenomenon. This research seeks to understand Canadian physiotherapists' lived experience(s) with their menopausal transition in their work settings. This case contributes to understanding the

experiences of menopause in the workplace and enhances knowledge about how healthcare professionals experience the menopausal transition.

There are 26,019 physiotherapists licensed to practice in Canada, 76% identify as women, and 53% are over the age of 40 years (CIHI, 2021). While this group of healthcare workers are negotiating symptoms of perimenopause in the work environment, they work in complex settings. Across ten provincial and territorial regulatory bodies, registered physiotherapists offer services in community settings (60%), hospitals (35%), long-term care (2%), universities (1%), and other locations (1%) (CIHI, 2021). Physiotherapists are trained professionals who help prevent and treat an injury, illness, or disability and play a vital role in all health sectors, from acute to long-term care. Physiotherapists work with patients to increase their quality of life, improve health outcomes, decrease hospital length of stay, and reduce future healthcare use (CPA, 2020).

There is a dearth of research exploring the impact of the menopausal transition on the individual, institution, and profession. With half of the physiotherapists experiencing menopause, the findings will evaluate how they view their overall health and how specific symptoms affect their work (Hay et al., 2016). In addition, the research will gain insight into individual, intermediate (i.e., workplace), and system-level (i.e., policies) factors that influence the quality of life, healthcare, and workplace experiences.

1.5 Research Question and Objectives

This research aims to, broadly, increase the understanding of the gendered dimensions of health and wellbeing concerning the transition to menopause and the perimenopausal experience within the work environment, using a case study of Canadian physiotherapists. Specifically, the aim is to explore the following question: How do place-based experiences in the work

environment impact physiotherapists undergoing the transition to menopause? The research addresses the following objectives:

1. To examine the relationships between aging, gender, health, and wellbeing in the workplace;
2. To explore the experiences of perimenopause for physiotherapists in the Canadian work environment; and,
3. To document the perceptions of existing structural support(s) in the workplace shaping physiotherapist's experiences with the menopausal transition.

1.6 Dissertation Outline

This dissertation covers eight chapters, including this Introduction. In **Chapter Two**, the work is situated within the relevant literature and discusses dominant discourses concerning the menopausal transition. In addition, this chapter includes a background of the physiotherapy profession to provide context to the case study explored in this research.

Chapter Three introduces the theoretical approach and informs the empirical investigation. In addition, the chapter explores feminism as a foundation for the theoretical approach of feminist geography applied in this research. Finally, the chapter concludes with an overview of the significance of integrating sex and gender in health research related to perimenopause.

Chapter Four describes the data collection methods and analytical strategies to address the research question and objectives. This chapter will focus on using Stake's approach to case study research, followed by an overview of the study context, ethical considerations and the sampling and recruitment strategy.

Chapter Five focuses on the findings from participants' experiences of being well at work organized according to three interrelated sub-themes; 1) finding balance, 2) transformative experience, and 3) redefining their purpose.

In **Chapter Six,** the analysis focuses on the embodied experience of perimenopause. This chapter presents the findings in three interrelated sub-themes; 1) the unpredictable body, 2) exploring the invisible, and 3) normalizing the transition.

Chapter Seven explores participants' experiences of navigating workplace support throughout the transition to menopause. The findings present the three interrelated sub-themes; 1) a time of reflection, 2) creating space for 'the change,' and 3) new alliances emerge.

Finally, in **Chapter Eight**, an overview of the critical findings of this research is provided, explicitly drawing on familiar themes identified across **Chapters Four, Five and Six** contextualized in the literature. Next, the chapter discusses the substantive, methodological, and theoretical contributions and concludes with the limitations and directions for future research.

Chapter Two: Literature Review

2.1 Introduction

The following chapter reviews the relevant literature concerning the transition to menopause and its influence on the workplace. First, the literature review explores the difference between menopause, perimenopause, and post-menopause. Next, the chapter highlights the literature related to the experience of menopause in the workplace. Subsequently, the chapter situates this research within the subdiscipline of health geography and continues by positioning how the research critically engages with health and wellbeing. The final section will provide context about the Canadian health care system and the physiotherapy profession as the case study for this research.

2.2 Narrative and Document Review

A narrative review captured the range of literature throughout this research. The SALSA (Search, Appraisal, Synthesis and Analysis) framework (Grant & Booth, 2009) guided the review of literature across different disciplines and methodologies (Efron & Ravid, 2018). A narrative review was relevant for this research as the literature spanned various disciplines, including medicine, psychology, nursing, business, and social sciences. In addition, there was a range of methodologies, methods, and data analyses in the literature. There was a significant amount of literature on menopause and perimenopause in the 1990s, then limited scholarly activity until the last three years. As a result, the review includes scholarly work across many decades and may not appear to be current/relevant literature.

The literature uses terms (i.e., perimenopause, menopause, postmenopause) interchangeably, requiring careful consideration of search words. The database search strategy included a combination of MeSH headings and keyword searches that were applied using the

Boolean operators "AND" and "OR." In addition, an English language limit was applied to each database search to identify relevant literature. Keywords included perimenopause, menopause, menopausal transition, menopausal change, midlife, change of life, climacteric, gender, gendered aging, feminist theory, feminist geography, health geography, qualitative, experiences, health, wellbeing, work, employment, job, physiotherapy, and health care professional, including contractions of those words or phrases. The search strategy for this literature review involved searching relevant electronic databases (PubMed, MEDLINE, CINAHL, ProQuest Databases/PsycINFO, Web of Science, EMBASE, Cochrane Library, Scopus). In addition, individual journals such as *Social Science and Medicine*, *Qualitative Research*, *Climacteric*, *Menopause*, and *Maturitas* were hand-searched for relevant literature.

Few studies examined the experience of menopause in the workplace; as a result, the relevant literature included the broader experience of menopause in the review. This narrative review was the first step in synthesizing the literature. Research is not linear and requires an ongoing engagement with the literature throughout the research process. The literature review in 2020 repeated in 2022 to capture the emergence of new publications on menopause in the workplace.

In addition to the narrative review, grey literature was collected to provide further context to the overall case (Stake, 1995). Document analysis is used in case study research (Wood, Sebar & Vecchio, 2020) and provides a systematic process to elicit meaning from documents (Bowen, 2009). The process is iterative and reflexive as the researcher (Bazeley, 2019) explores if documents exist related to the menopause transition in the workplace. Finally, the READ approach reviewed documents in the context of menopause in the workplace (Dalglish et al., 2020). The READ approach includes four steps: 1) get materials ready, 2) extract data from the

materials, 3) analyze data, and 4) distil findings for critical information in alignment with the research objectives.

The types of documents included official (policies, position papers), implementation materials (training manuals, reports), legal documents (legislation, regulations), working documents (meeting reports), and media and communications (newspaper and magazine articles and podcasts). The documents examined aging policies and workplace guidelines, specifically menopause. While the focus was on the Canadian workforce, the research captured national and global policies where there was innovative work in this area. Relevant results were screened into the review, while excluded documents included results not addressing perimenopause or menopause at work. The document review was an iterative process, and data collected by participants guided decisions on the number and types of documents.

2.3 Perimenopause and Menopause

Menopause is also known as the climacteric, midlife and change of life. Menopause can only be defined once menstruation has ended for twelve consecutive months. In menopause, a person's hormone levels continue to drop and may fluctuate, and the effects may take several years to disappear (Harlow et al., 2012). Much of the evidence defaults to *spontaneous or natural menopause* with the cessation of the menstrual cycle without any pathological causes (Utian, 1999). However, there are differences in timing and the causes that lead to the final menstrual period (FMP). For example, *surgical menopause* occurs due to medical procedures such as the surgical removal of ovaries, uterine cancer, or endometriosis (Harlow et al., 2012). While *induced menopause* results from damage to the ovaries caused by radiation or chemotherapy (Santoro, 2016; NAMS, 2020). *Early or premature menopause* occurs before age

40, and about 5% of women naturally go through early menopause due to genetics or autoimmune disorders (Shifren et al., 2014).

Perimenopause is a new term in the academic literature and for medical and health professions. The term was often subsumed into menopause and captured any hormonal changes for women over forty. In response to this confusion within the academic and medical community, the World Health Organization (WHO) organized a scientific group of experts to review information on menopause and standardize the nomenclature. This group of experts differentiated perimenopause from menopause as the time immediately before menopause (WHO Scientific Group, 1996) and when the biological features of menopause begin (Utian, 1999). The most significant medical sign that a person is perimenopausal is a decrease in estrogen (McCarthy & Raval, 2020; Torpy et al., 2003). Evidence supports the clinical importance of perimenopause as a period of temporal changes in health and longer-term changes in health outcomes (i.e., urogenital symptoms, bone, lipids) (Utian, 1987; Sowers & La Pietra, 1995). However, there is a significant range of experiences related to the duration, severity, and types of perimenopausal symptoms (Dillaway, 2005b). The common clinical symptoms during perimenopause include vasomotor, irregular menstrual cycle, and mood disorders (Whiteley et al., 2013). Additional signs such as headaches, fatigue, mood changes, brain fog, sleeping issues, and joint pain may also be associated with other health problems, not specifically with menopause (Geukes et al., 2016). This complex set of symptoms creates confusion and a lack of clarity about the impact of perimenopause and menopause on individuals (Verburgh et al., 2019).

Perimenopause begins four to eight years before menopause (Chan et al., 2020), with this starting point unique to each person (Kuh et al., 2018). The typical age of menopause is between 40 and 55 years (Utian, 1999). The WHO states that menopause occurs between 45-55 years

around the world (WHO, 1996). The average age of menopause in Australia is 51.7 years (Schoenaker et al., 2014) and 44 years in India and the Philippines (Sharma & Saxena, 1981; Goodman et al., 1985; Ringa, 2000), while many countries in Africa, the age is 50 years (Ramakuela et al., 2014; Hill, 1996).

Despite WHO's efforts to clarify terminology, misunderstanding and a lack of awareness continue about the phases at the end of the reproductive years (Ambikairajah et al., 2022). Lack of clarity of definitions also leads to confusion about managing and treating symptoms associated with hormonal changes throughout the transition into menopause. To address this continued lack of consistency in definitions, diagnosis and management, the Stages of Reproductive Aging Workshop (STRAW) was organized and proposed an updated standardized nomenclature for reproductive aging and was considered foundational for understanding and defining this significant life cycle (Soules et al., 2001). After a decade of research, a follow-up workshop evaluated and updated the framework to capture new evidence and advancements in understanding perimenopause and menopause (Harlow et al., 2012). The result of this work was STRAW+10, which provides a biomedical classification of menopausal status (Burger, 2013). As a clinical tool, the STRAW+10 criteria provide healthcare providers with a resource to guide the assessment of fertility, contraceptive needs, and healthcare decision-making (Harlow et al., 2012). STRAW+10 divided adult life into three broad phases: reproductive, menopausal transition, and postmenopause (Jane & Davis, 2014), with simplified bleeding criteria that can be applied regardless of age, ethnicity, body size or lifestyle characteristics (Harlow et al., 2012). However, while the data from the STRAW+10 provides clinical and medical data, it overlooks the psychosocial dimensions of the perimenopausal and menopause experience (Suss et al., 2021).

Dr. Charles de Gardanne first documented menopause as a syndrome (Singh et al., 2002), leading future medical practitioners to focus on the symptoms and maladies of menopause (Haspels & van Keep, 1979). Initially, women sought medical advice and treatment from midwives. Over time, the medical profession, supported by the pharmaceutical industry, began focusing on treatment options based on hormone therapy (Palmlund, 2006; Padamsee, 2011). Physicians prescribed estrogen for menopausal symptoms, including hot flashes, headaches, and irregular bleeding (Palmlund, 2006). For decades, menopause was described as a "hormone deficiency disease" (Newhart, 2013) and expanded from physical symptoms to include mental health and psychiatric concerns (Coney, 1991). However, the connection between hormone changes and mental health requires additional research (Gunter, 2021). For decades, women were diagnosed with depression (involutional melancholia) as a severe symptom of menopause (Burrows & Dennerstein, 1981). Since the 1960s, studies have provided inconclusive evidence that depression had distinct symptoms in menopausal women (Winokur, 1973) and the Diagnostic and Statistical Manual (DSM) removed involutional melancholia as a psychiatric disorder (Weissman, 1979; Coney, 1991). Investigation continues into the association between menopause and mental health (i.e., depression and anxiety) (Gambaudo, 2017).

The discourse around menopause and its relationship to public health expanded in the 1990s with a dialogue about chronic disease prevention during midlife (Rosenbaum, 1998). For example, the medical profession makes a link between hormone changes and cardiovascular disease to promote healthy lifestyles and increase hormone therapy (El Khoudary et al., 2020). However, further research is required to understand the implications of hormone therapy throughout the menopausal transition. One response was an American study, the Women's Health Initiative (WHI), funded by the National Institute of Health (NIH). This fifteen-year

randomized control trial studied the relationship between hormone therapy with menopausal women. Unfortunately, the study ended in 2002 due to early findings showing an association between hormone therapy and an increased risk of breast cancer, coronary heart disease, and stroke (Brown, 2012). The sudden stop of the study created panic and uncertainty about the safety of hormone therapy in the medical profession and the public (Brown, 2012). In addition, the controversy around the management of menopause resulted in a significant decline in the use of hormone therapy as part of treatment plans for menopausal patients.

The implications of the WHI had a significant global impact on the treatment of menopause (Herbert et al., 2020). A global agreement on hormone therapy through the European Menopause and Andropause Society (EMAS) released the Global Consensus Statement on Menopause Hormone Therapy. The Statement, released in 2013, was endorsed by the International Menopause Society (IMS) and the North American Menopause Society (NAMS) (de Villiers et al., 2013) and later updated in 2016. The Statement includes a guideline for hormone therapy for menopause under the age of sixty (de Villiers et al., 2013).

In Canada, the guidelines published for managing menopausal symptoms through the Society of Obstetricians and Gynaecologists of Canada (Yuksel et al., 2021) in collaboration with the International Menopause Society (IMS), the North American Menopause Society (NAMS), and the Endocrine Society (ES). The guidelines advise that treatment is tailored to each person's unique needs and regularly reassessed (Yuksel et al., 2021). In addition, the guidelines recommend a holistic approach, including lifestyle changes, alternative treatment, and an understanding of the patient's medical history (Yuksel et al., 2021).

2.3.1 Factors Impacting Perimenopause

People who go through the menopausal transition will have unique experiences influenced by multiple life factors (Hall et al., 2007; Mackey, 2007). The lived experience does not occur in isolation, particularly as we consider the perimenopausal phase of life. The literature explores factors including individuals' knowledge of perimenopause, life stressors, parental status, relationship status, social support, culture, and inclusivity. The following section explores these factors in more detail.

Knowledge and Awareness. Knowledge and awareness about this natural transition are critical to managing symptoms and improving the quality of life (Gayathripriya et al., 2018). However, the literature shows that women have insufficient knowledge about menopause, including the potential complications and management (Hoga et al., 2015; Donati et al., 2009; Hamid et al., 2014). While some studies show participants with good knowledge about menopause, they were unaware of health impacts and management (Khokhar, 2013; Bertero, 2003). This lack of information and limited understanding of menopause negatively impact quality of life (Zolnierczuk-Kieliszek et al., 2014; Tsao et al., 2004).

Healthcare professionals have varying levels of understanding and engagement with perimenopausal patients. The research found that 60% of 3135 perimenopausal and menopausal people reached out for support from healthcare professionals about menopause (Williams et al., 2007). A scoping review focused on how menopause is taught in healthcare professional education and concluded that there is a significant gap in evidence-based menopause training (Macpherson & Quinton, 2022). This lack of training extends to undergraduate medicine (Schnatz & Marakovits, 2008), postgraduate medical education (Kling et al., 2019), and the

health professions (Lin et al., 2020). Menopause is complex and will require pedagogy that reflects beyond symptom management and includes the experiences across all domains of life.

A qualitative study explored the impact of a podcast series on participants' knowledge of menopause (Edwards et al., 2021). The findings showed that the podcast helped women learn about the menopause experience, have an increased sense of support and community, and feel empowered to make decisions in their lives (Edwards et al., 2021). In addition, research shows that menopause symptoms negatively impact the quality of life and are positively influenced by social support (Hess et al., 2012; Zhao et al., 2019). However, research also shows limited support and a sense of isolation during this life stage (Im et al., 2010; Koch & Mansfield, 2004; Utz, 2011).

Life Stressors. Perimenopause occurs when other life stressors may be happening, including new health issues, children leaving home, aging relatives, and the end of relationships (Brown, Bryant, & Judd, 2015; Busch et al., 2003; Lindh-Åstrand et al., 2007; Loh et al., 2005; Mackey, 2007; Smith-DiJulio, Woods, & Mitchell, 2008; Winterich & Umberson, 1999). These stresses add to the perimenopausal changes and, for some individuals, make it difficult to manage (Loh et al., 2005). Smith-DiJulio et al. (2008) found a correlation between decreased scores on wellbeing measures during perimenopause and related adverse life events. Continued research that examines the connection between life stressors and the menopausal transition is warranted (Brown, Bryant, & Judd, 2015).

Parental status. Pregnancy and the role of parenting may influence the experience of perimenopause. This time can be difficult for individuals who cannot have children or want more children (Strauss, 2011; Rossi, 2004). While for others, the end of fertility provides relief and freedom (Herbert et al., 2020). The age and timing of individuals' children may impact their

experience with perimenopause. There is limited research exploring the experience of pregnant individuals at an advanced age and menopause (El Khoudary et al., 2019).

Relationship Status. Personal relationship status impacts the perimenopausal experience (Delanoe et al., 2012; Dillaway, 2005a; Hyde et al., 2011). Some research reports that partners are unaware of perimenopause and have not been supportive of symptoms and changes (Delanoe et al., 2012; Dillaway, 2005b). In contrast, other partners have supported and engaged in learning more about perimenopause (Durham, 2009). This time can present challenges for single individuals as they negotiate the physiological changes of perimenopause (Hill, 2021).

Generational Support. Through a qualitative research study with 61 women aged 38 to 60, participants compared their experience to their mother's menopause (Dillaway, 2007). Many participants did not know much about their mother's experience as it was not discussed or shared in the household (Dillaway, 2007). However, Utz (2011) interviewed 50-year-old women and their mothers about menopause, showing the different attitudes across generations. Key factors influencing this difference included the marketing of hormone therapy and social media as sources of information for the younger generation (Utz, 2011). Consideration of knowledge transferred between generations, particularly within families, requires further investigation.

Social Supports. Social support can influence successful coping strategies throughout menopause (Zhao et al., 2019). The national research program on menopause (the SWAN study) showed that social supports were critical in reducing mood disorders in women during perimenopause (Bromberger et al., 2007). In addition, social support reduces stress exacerbating vasomotor symptoms (Arnot et al., 2021). In contrast, other studies could not confirm a correlation between social support and quality of life throughout the menopause transition (Binfa et al., 2004; Blumel et al., 2004). The complexity of social support and menopause is critical to

understand, including defining the support network. For example, a qualitative study with 18 perimenopausal Thai women highlighted the importance of sharing menopausal experiences with other women and through support groups to facilitate this time of transition (Noonil et al., 2012). At the same time, a cross-sectional study in Vietnam demonstrated the alleviation of negative menopausal systems through social support associated with exercise and recreational activities (Nguyen et al., 2022). Consideration of social supports, including defining these supports, warrants further investigation.

Culture and Ethnicity. While common perimenopausal experiences exist, differences occur between and within cultural and ethnic groups (Delanoe et al., 2012; Im et al., 2010). For example, a study exploring the perimenopausal experience of African Americans highlighted the significance of remaining silent about this time of life among participants exacerbated by the perception that the health care system does not care about them (Aririguzo et al., 2022). A review of research about Canadian Indigenous People's perception of perimenopause showed that freedom, self-discovery, and self-reflection were central as they moved into more decisive roles within their families and communities (Halseth et al., 2018; Loppie, 2005; Meadows et al., 2004). Cultural and historical factors shape the perimenopausal experience yet require significant investigation to understand the lived experience(s) to address care through a culturally sensitive foundation.

Inclusivity of Perimenopause. The experience of cisgender women frames the dialogue on social media and research about menopause (Mohamed & Hunter, 2019). However, transgender women, trans men and non-binary people may experience symptoms of menopause if they keep their ovaries and do not change their hormone profile (Glyde, 2021). In addition, not all females menstruate, and not all people who menstruate identify as female (Rydstrom, 2020).

There is limited research on the experience of menopause or perimenopause as a transgender individual (Mohamed & Hunter, 2019). However, there are British-based organizations (i.e., Henpicked and Global Butterflies) leading dialogues and training about the experience of menopause for health professionals and employers to better support trans and non-binary people (Glyde, 2022).

2.3.2 Menopause and the Workplace

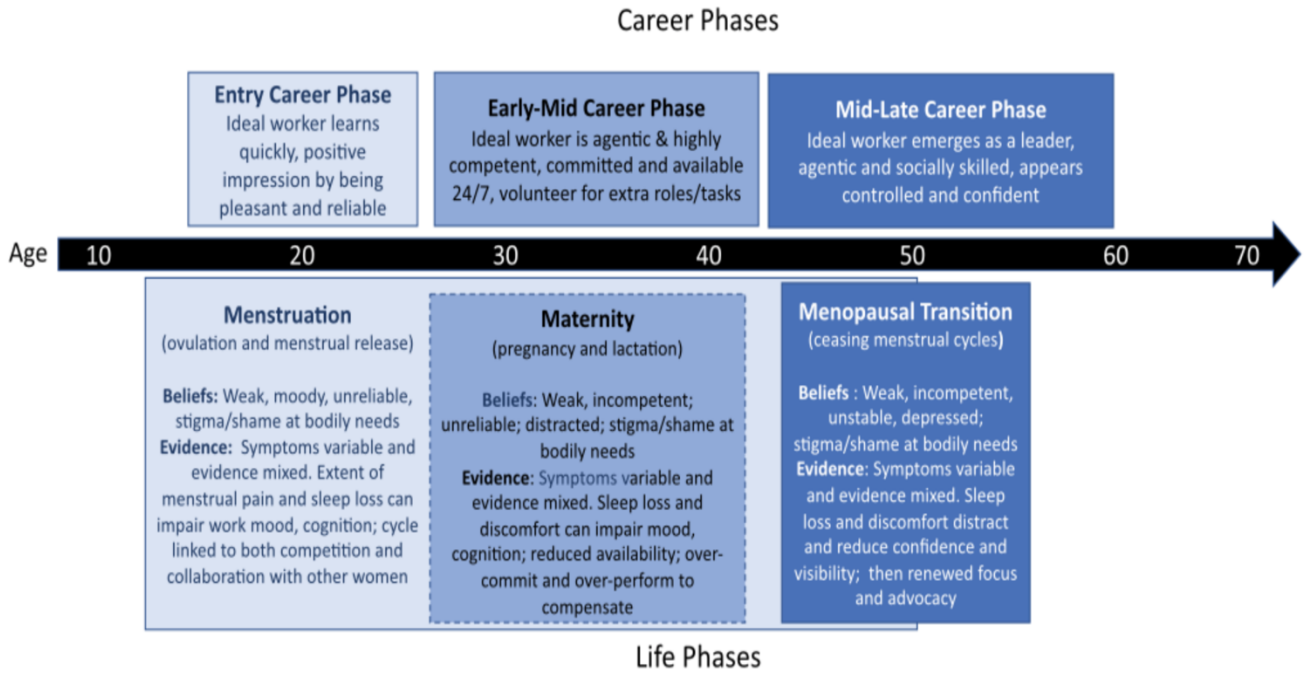
Biological, psychological, social, and cultural factors influence the menopause experience (Dashti et al., 2021). Menopause is often medicalized and pathologized, focusing on the deficiency and loss of function (Hyde et al., 2010; Putnam & Bochantin, 2009). This framing of menopause is reinforced through social media (Phillips, 2022; Beck et al., 2020) and is part of the narratives of older women in society (Farrugia-Bonello, 2021; Utz, 2011). Attitudes toward women's roles, particularly negative ones, are socially and culturally constructed (Farrugia-Bonello, 2021; Shilling, 2008; McDowell, 1999). An alternative discourse, guided by a feminist framework, defines this transition as a natural part of life and begins to explore other factors which affect women during this time, including work, family, relationships, and caregiving roles (Lazar et al., 2019; Dillaway, 2005a; Hyde et al., 2010; Jack et al., 2019).

As perimenopause occurs between 40 and 50 years, intersecting with a critical career stage (Huffman & Myers, 1999), focusing on work and menopause is critical. During this time, women are most likely to move into leadership positions and take on additional work responsibilities (Patterson, 2020; Utian, 1999). Since perimenopause generally lasts between seven and 14 years, millions of women enter management and leadership roles while experiencing mild to severe symptoms such as depression, anxiety, sleep deprivation and cognitive impairment (Brewis et al., 2017).

Acker (1990) highlights the ideal worker as healthy, predictable, and reliable. Meanwhile, Grandey et al. (2020) explores the relationship between career trajectory and the reproductive life phases known as the three *M*s (menstruation, maternity, and menopause). Consideration of the three *Ms* starts to challenge the sense of an ideal worker when the body experiences can create an unpredictable employee who must manage these uncertainties (Jack et al., 2019).

While an exploration of menopause in the workforce is emerging, the discussion of menstrual health has also been growing (Hardy et al., 2018; Verdonk et al., 2022; Beck et al., 2020). Institutions are recognizing the need to provide support to employees through menstrual leave policies (Levitt & Barnack-Tavlaris, 2020) in Japan (Hashimoto et al., 2021), Taiwan (Baird et al., 2021), China (Verdonk et al., 2022), and Zambia (King, 2021). Employees reference the benefits of these policies in reducing stigma and creating space for open dialogue about menstruation (Levitt & Barnack-Tavlaris, 2020). However, the unintended consequences of these policies contribute to sexist beliefs and attitudes, maintain stereotypes and stigma, and support the medicalization of menstruation (Levitt & Barnack-Tavlaris, 2020; King, 2021). As institutions develop menstrual health policies, engaging their workforce must have meaningful and relevant structures (Steffan, 2021). In addition, identifying evidence-based approaches based on gender dimensions is critical to effective policy development and implementation (Hardy, 2020).

Figure 2 highlights the intersection between career trajectory and the reproductive cycle. Recognizing that careers are not linear, women may come in and out of the workforce for various reasons (Grandey, Gabriel & King, 2020). For example, not all employees will experience maternity, and some people may engage in the maternity cycle multiple times (Mainiero & Sullivan, 2005).



Grandey, Gabriel & King, 2020

Figure 2: Intersection of reproductive life phases with career phases

There is a perception that discussing menopause within the work institution is taboo (Whiteley et al., 2013). As a result, employers have limited awareness of the support required for the transition to menopause (Viotti et al., 2020; Williams et al., 2009; Sarrel, 2012). A lack of awareness and poor knowledge of the menopause transition have negatively impacted productivity (Hammam et al., 2012). In addition, Brewis et al. (2017) discovered a fear of disclosing menopausal status as it could limit career options and growth (Atkinson et al., 2015).

Considering that situational context (i.e., public speaking) may precipitate or exacerbate symptoms affecting women's perceptions of the severity of their symptoms (Geukes et al., 2012). Research explores a range of coping strategies to manage symptoms within the workplace environment, including humour, support from other women, education, focusing on tasks (i.e., making lists), changing work hours, and personal care (i.e., exercise, sleep, diet) (Griffiths et al.,

2013). Unfortunately, many people cannot identify appropriate coping strategies in their work setting during the menopause transition (Ngome & Ama, 2013). Therefore, the literature explores psychological interventions for anxiety and self-esteem (Smith et al., 2011), mainly focusing on cognitive behaviour therapy (CBT). Ayers et al. (2012) concluded that CBT effectively improves confidence and the ability to cope with symptoms of menopause, particularly in a work setting.

The literature recognizes differences across professions in the treatment, discussion, and experience of menopause (Whiteley et al., 2013). However, limited research explores these unique experiences to frame a collective understanding of the transition to menopause across work environments (Brewis et al., 2017). Some literature explores the experience of menopause within specific professions, including the police force (Atkinson et al., 2021); physicians (Geukes et al., 2020), university employees (Besen et al., 2021), administrative staff (Viotti et al., 2021), ambulance staff (Prothero, Foster & Winterson, 2021), dentists (Bell et al., 2022), and medical school faculty (Hammam et al., 2012). To date, there are no studies about rehabilitation health professionals or physiotherapists' experience with menopause or the menopausal transition.

A growing number of institutions in the United Kingdom and Australia have developed menopause policies, training, and support for managers (Jack et al., 2021). In addition, some institutions engage in an accreditation process to endorse workplaces as menopause friendly. This process requires institutions to meet criteria under six elements: culture, policies and practices, training, engagement, facilities, and evaluation (Henpicked, 2020). An expert independent panel and organizations that assess these criteria must provide continuing

professional development, certification training, and workshops focused on menopause and the workplace (Henpicked, 2020).

Meanwhile, national governments acknowledge menopause as a workplace issue through awareness campaigns, education programs and policy development. (Beck et al., 2018). For example, in Australia, the government instituted a national women's strategy (2020-2030) with menopause integrated across the life course (Riach & Jack, 2021). The Equality Act 2010 in the United Kingdom included menopause discrimination under three protected characteristics (age, sex, and disability discrimination) (Hardy et al., 2018). This work was foundational to the 2017 Government Equalities Report on menopause at work, in which menopause became a distinct characteristic (Brewis et al., 2017). In 2021, the United Kingdom's House of Commons Women and Equalities Committee established a Menopause Taskforce to understand the issues in the workplace and determine recommendations to move forward (Hacking & Mander, 2022). This Taskforce completed a survey in September 2021 and heard from expert witnesses from November 2021 to March 2022. In 2022, the Taskforce will publish a report with findings (Wisenberg Brin, 2022).

The literature explores how the stages of menopausal transition impact women's health through occupational experiences (i.e., burnout, job involvement and hardiness) (Hickey et al., 2017; Brewis et al., 2017). However, few studies examine women's experience of menopause in the workplace (Butler, 2020; Jack et al., 2019; Atkinson et al., 2021) with a focus on the symptoms and coping strategies of menopausal symptoms (Griffiths et al., 2016; Jack et al., 2014). Women experiencing menopausal symptoms such as depression, joint stiffness, anxiety and memory loss report significantly higher absenteeism and overall work impairment (Whiteley

et al., 2013). In addition, severe vasomotor symptoms are three times more likely to harm women's work (Smith et al., 2011).

In 2018, the Canadian labour force participation rate was 61.4% for women, making up 58.2% of the employment rate during this same period (Stats Canada, 2019). The demographics show an increasing number of women aged 50 and over in employment (Williams et al., 2009). However, 2.7 million Canadian women will reach menopause over the next decade (Rowe, 2021). While a growing number of employees who face perimenopause are engaged in the Canadian labour market, studies have yet to explore this experience.

Empirical evidence rarely provides the voice of menopausal people describing in their own words how they experience perimenopause, health, and wellbeing (DeLeyser & Shaw, 2013) and that experience in the work environment (Verdonk et al., 2022; Griffiths & Hunter, 2014). Additional research is required to understand the relationship between menopause and work ability, job performance, and organizational structures (Verdonk et al., 2022).

The following section will provide an overall framing of health geography as the subdiscipline for this research. In addition, the section will demonstrate the unique lens of health geography in exploring the experience of perimenopause in the workplace.

2.4 Health Geography

In the 1990s, a debate emerged for a "new" geography of health that would be socially informed (Kearns, 1993) and advance our understanding of biomedical models of geography that previously focused on disease ecology and health care services (Kearns & Moon, 2002). Critiquing medical geography for its detached focus on location and lack of appreciation of the nuances between, across and within communities (Jones & Moon, 1993), Kearns (1993) called for new health geography that focused on place, sociocultural understandings of health, and

humanism. Through this dialogue, the distinctions between the two approaches of medical geography began to soften with an emphasis on wellbeing, determinants of health, and the significance of place (Kearns & Moon, 2002). In addition, researchers supported incorporating sociocultural theories to examine the complex relations between people, place, and health (Dyck, 2003; Kearns & Moon, 2002). The expansion of 'medical geography' to 'health geography' enhanced disciplinary foci, reflected in changes in research, practice and health care settings (Kearns, 1993).

Increased attention to place in structural systems prompted a difference in the subdiscipline (Jones & Moon, 1993; Kearns & Moon, 2002). As reformed health geography emerged, place became central to recognizing socio-ecological models, local context and lived experience as contributors to understanding health and wellbeing (Kearns, 1993; Kearns & Moon, 2002). Place is a geographic space charged with meaning where social relations and identity construction occurs (Gesler & Kearns, 2002). Characteristics of place vary and can support or restrict health (Gatrell & Elliott, 2015) and is framed around the lived experience to understand the relation and meaning between environment and health (Thrift, 1983; Cloke & Johnston, 2005). By challenging medical geography's theoretical underpinnings (Litva & Eyles, 1995) and neglect towards the role of place (Kearns, 1993), the subdiscipline began to engage with social and cultural theories to investigate the complex relations between people, place, and their health (Dyck, 2001; Kearns & Moon, 2002).

Theoretical debates on structure and human agency influenced human geography. Giddens' (1984) concept of 'duality of structure' gave meaning to structures in both the medium and the outcome of the social practice. Therefore, people shape structure, but structure also determines

what people do. People engage in various settings, and how individuals manage their health could depend on how they relate to and engage within these settings (Giddens, 1984).

Research theoretically grounded in disease ecology focuses on how humans interact with the physical environment to prevent disease (Rosenberg, 2014). An epidemiological perspective examines health, illness and disease as transmitted through space by mapping and modelling spatial patterns. Research acknowledging the relational qualities of the individual, environment, and health, can help explore the association between these individual and contextual factors that shape health (Cutchin, 2007; Cummins et al., 2007). Through this approach, health research gains a comprehensive understanding of the individual and place variables while recognizing the dynamic relationship between them.

Macintyre et al. (2002) proposed a framework for conceptualizing geographic variations in health. This framework included three variables: compositional, contextual, and collective. Compositional variables include socio-demographic characteristics, such as age, sex, ethnicity, employment, and income (Collins et al., 2017). The contextual variables explore a region's broader social and physical opportunities, such as availability and access to services. Finally, adding collective variables engages a region's sociocultural and historical features, including norms, values, and levels of social cohesion (Armah et al., 2015). Understanding the historical and sociocultural elements is essential to understanding place and health. While engaging these three variables deepens the analysis of health inequalities with biological factors and socio-ecological structures (Fleuret & Atkinson, 2007).

Robert et al. (2004) explored how perceived compositional, contextual, and collective community factors might enhance our understanding of breast cancer rates in Wisconsin, USA. Higher rates of breast cancer are the complex interaction between individual characteristics (e.g.,

age, mammography use, family history of breast cancer, menopausal status, alcohol intake, body mass index) and the contextual factors (e.g., physical environment, living in a higher socioeconomic and urban community). In addition, the analysis must include the interaction between community norms and values, social cohesion, and access to health services (i.e., collective) (Collins et al., 2017). A richer understanding of health and wellbeing will benefit from exploring the variables associated with people and places (Jones & Moon, 1993) in relation to each other. Exploring the interaction of social context and lived experience provides a holistic understanding of the intersections between compositional and contextual variables across settings (Thurston & Meadows, 2004).

Place provides a lens through which to explore the dynamic relationships between contextual-compositional-collective factors that produce health (Gatrell & Elliott, 2015; King & Crews, 2013; King, 2010). Place also helps highlight that health and wellbeing are context-specific, co-constructed and maintained across geographic scales (Cutchin, 2007; Cummins et al., 2007) while framed around the lived experience to understand the relation and meaning between environment and health (Cloke & Johnston, 2005; Thrift, 1983). The centrality of place in shaping our life experiences is evident in how it influences our health and wellbeing (Neely & Nading, 2017).

While the population ages, the places where people age has received limited attention in academia and policy settings (Skinner et al., 2018). This research seeks to understand the impact of place on aging (Wiles et al., 2012), including the relationship of the work environment to an aging workforce (StatsCan, 2019; Pitt-Catsouphes, 2007). The workforce has an increasing number of women aged 45 and over (Hennekam & Dumazert, 2021; Tilly et al., 2013; Williams et al., 2009). However, there needs to be more research to understand the unique needs of women

and trans/non-binary people aging in the work environment (Jack et al., 2021; DeLyser & Shaw, 2013). Exploring gaps in the experience of aging in the workplace creates opportunities to negotiate meaning and identity as part of the integration within place and across time. This research supports the exploration of gendered aging in the workplace by focusing on the menopausal experiences of health care providers.

How people interact and view place shapes health and wellbeing (Deryugina & Molitor, 2021; Conradson, 2005), this work requires further attention in two areas. First, the relationship between aging, health, wellbeing, and place, specifically through a gender lens in the work environment, has a dearth of literature and exploration within human geography (Franklin et al., 2021). Second, there is a need to understand multiscale and multitemporal aspects of place to inform health and wellbeing outcomes in the workforce (Barakovic et al., 2020). Health geography plays a vital role in exploring the relationship between aging, health and wellbeing, gender, and place to dive deeper into these areas.

2.5 Critical Engagement with Health and Wellbeing

Our understanding of health and wellbeing continues to emerge; these debates are influential in this research. For example, Engel (1960) proposed to broaden the biomedical definition of health to include a biopsychosocial framework in which medicine must include psychosocial (i.e., emotional, social supports) and biological (i.e., diseases) aspects when considering the health of individuals. While there was criticism of Engel's systems approach to health (McLaren, 2021; Lugg, 2022), his work advanced discussions in the medical community and expanded scholarly dialogue to explore health outside the disease-focused biomedical model (Engel, 1997).

In 1948, the World Health Organization (WHO) defined *health* as a "complete state of physical, mental, spiritual and social wellbeing and not merely the absence of disease or infirmity" (WHO, 1948, para. 1). This comprehensive definition adopted by health disciplines, including health geography, incorporates socio-ecological perspectives (Kearns, 1993). For example, WHO's Commission on Determinants of Health reported that the global burden of disease, and significant causes of health inequities, arise from the different conditions in which people are born, grow, live, work and age (Marmot et al., 2008). These conditions are affected by inequities in power, money, and resources, and all are affected by gender.

For this research, health is also understood as a resource to ensure people manage, cope, and change their environments (Elliott, 2018). Health is socially constructed in place (Dummer, 2008). Through this lens, health is dynamic, multidimensional, and on a continuum influenced by the environments in which individuals live, work and play. Applying context to examine health and its determinants will strengthen the analysis of health and wellbeing (Kearns, 1993; Kearns & Moon, 2002; Litva & Eyles, 1995), particularly in this research, as we explore the meaning of gendered place-based experiences in the work environment.

Wellbeing is complex and multidimensional and extends beyond health to include material wellbeing (income and wealth), environment(s), and all things that matter for a good life (Deaton, 2013). Lived experiences and unique cultural, social, and economic environments are critical to wellbeing (Panelli & Tipa, 2007). Health geographers focusing on wellbeing have aligned their research and discourse with the role of culture and place (Kangmennaang & Elliott, 2019; Richmond et al., 2005). This research will explore the relationship between wellbeing, quality of life and menopause as a significant life event.

This research adopts and extends the WHO Commission on Social Determinants of Health as a framework recognizing the role social factors (i.e., non-biomedical factors) play in shaping the health and wellbeing of individuals and populations. By conceptualizing outcomes of poor health and wellbeing as products of economic and social inequality, the determinants of health provide the conceptual space to begin examining how various socioeconomic factors mediate the relationship between age, gender, health, and wellbeing (Read, Grundy & Foverskov, 2016). In addition, a determinant of health perspective helps understand health and wellbeing if it is rooted in critical perspectives that seek to understand the production of power, intersectionality, and shifting relationality (Holman & Walker, 2021; Hankivsky & Christoffersen, 2008).

2.6 Understanding the Physiotherapy Profession

Physiotherapists help prevent and treat injury, illness, and disability. Physiotherapists play a vital role in all health sectors, from acute to long-term care, relying on teamwork, skills, knowledge and understanding for patient care (Walton, 2020a). Physiotherapists work in clinical areas, including neurology, oncology, rheumatology, orthopedics, obstetrics, pediatrics, and geriatrics. In addition, they are experts in treating patients with cardiovascular and cardiopulmonary disorders, burns and sports injuries (Conference Board, 2017).

An estimated 660,000 physiotherapists work in health care in 125 countries (WCPT, 2020). There are different credentials and education worldwide, despite the unifying definition of physiotherapy provided by the World Confederation of Physiotherapy (WCPT, 2020). The WCPT defines the overarching roles of physiotherapy as assessing patient needs, making clinical judgments, developing a diagnosis and plan, consulting patients, implementing an intervention, and providing a treatment plan (WCPT, 2020). National physiotherapy associations define the roles and scope of practice for each jurisdiction. For example, in Canada, physiotherapists are

experts in movement and physical function while focusing on managing and preventing acute and chronic disease, injury, and health promotion (Walton, 2020b).

In Canada, the responsibility for most health services falls under provincial and territorial jurisdiction, supported by the federal government, and directed by the principles of the Canada Health Act (Marchildon, 2008). The Canada Health Act states that the "...primary objective of Canadian Health Policy is to.... facilitate reasonable access to health services without financial or other barriers" (Government of Canada, 1985). For example, the Canada Health Act includes physiotherapy with hospital care, and each province has a regulatory body that further defines the scope of practice in that jurisdiction (Walton, 2020b).

There are 15 entry-to-practice physiotherapy education programs in Canada, each conferring a professional degree (Newell, 2020). Ten of these programs are master's level, while five combine bachelor's and master's programs, with ten programs in English and five in French (Newell, 2020; CCPUP, 2019). The programs are two years in duration, and student physiotherapists are taught and assessed by faculty and clinical preceptors (CAPR, 2019). Physiotherapy curricula in Canada are guided by the National Physiotherapy Entry-to-Practice Curriculum Guidelines 2019 (CCPUP, 2019). The Curriculum Guidelines focus on curricular content supporting the essential competencies and the milestones of the Competency Profile (CCPUP, 2019). This competency profile is the foundation for physiotherapy education and sets physiotherapy accreditation standards (NPAG, 2017). For a student to successfully graduate, they must complete seven domains of practice with 34 essential competencies and 140 entry-to-practice milestones. In addition, students must complete 1025 practice hours with a minimum of 820 hours of direct patient care (PEAC, 2016).

Accreditation is an independent, external evaluation to ensure that the quality of education delivered by the programs in Canada meets a set of recognized standards (PEAC, 2020). Only students graduating from accredited physiotherapy programs are eligible to sit the Physiotherapy Competency Exam required for licensure (CAPR, 2021). The accreditation process is completed by PEAC at least every six years according to the Accreditation Standards (PEAC, 2020). There are six accreditation standards for physiotherapy education programs: (1) program governance and resources, (2) program development and evaluation, (3) faculty, (4) students, (5) accountability, and (6) physiotherapy competencies (PEAC, 2012).

The Competency Profile, Accreditation Standards and Curriculum Guidelines are foundation documents guiding physiotherapy education and practice in Canada (CPA, 2021). In addition, provincial and territorial legislation, codes of ethical conduct and standards of practice underpin physiotherapy practice (Walton, 2020b). For example, each province has a Physiotherapy Act that oversees the profession, ensures ethical practice, and licenses physiotherapists in that province or territory (CPA, n.d.).

There are about 1200 physiotherapy students annually in Canada (CCPUP, 2020). In addition, there are about 6500 internationally educated physiotherapists working in Canada who trained outside the country (CIHI, 2020). British Columbia, Ontario and Alberta have the highest percentages of internationally educated physiotherapists (30%, 29% and 25%, respectively), while New Brunswick and Quebec have the lowest (3.2% and 1.2%, respectively) (CIHI, 2020). The Canadian Alliance of Physiotherapy Regulators (CAPR) evaluates and administers the national exam for internationally educated physiotherapists (CAPR, 2022). In addition, a provincial or territorial regulatory body approves a licence to work as a physiotherapist in Canada (CAPR, 2022).

Demand for high-quality, effective, and sustainable health care services is a pressing challenge facing governments and businesses (Walton, 2020c). Physiotherapists have an essential role in addressing these challenges by promoting active lifestyles and rehabilitation for seniors and the general population, thus contributing to improved health system performance (Tawiah et al., 2021). Physiotherapy has demonstrated effectiveness in all practice areas by increasing quality of life, improving various health outcomes, and decreasing hospital length of stay and future health care use among patients (Powner et al., 2019). Physiotherapists can also create a more efficient health care system by focusing on primary care, injury prevention, and rehabilitation (Walton, 2020c). There is also a growing role and need for physiotherapists with changing demographics and rising chronic illnesses (Walton, 2020a).

In Canada, physiotherapists work in many settings, including hospitals, schools, universities, government, businesses, and communities (Walton, 2020b). Employment rates for physiotherapists have risen sharply with a shift in service delivery from hospitals to community-based providers (Walton, 2020a). The practice area divides physiotherapists between general and musculoskeletal practice (Walton, 2020b). There are 26,019 physiotherapists licensed to practice in Canada across ten provincial regulatory bodies offering services in hospitals (34%), community (58%), long-term care (2%), universities (2%), and other settings (4%) (CIHI, 2019). Of the 26,019 physiotherapists in Canada, 75% identify as female, and 52% of these females are over the age of 40 years (CIHI, 2020). Of note, CIHI aligns with Statistics Canada's reporting categories of females and males for gender identity and sex at birth.

The desire to help others (Harman et al., 2021) and a sense of altruism (Price et al., 2021) draw individuals to the profession. Exploring the formation of professional identity provides insight into the culture of physiotherapy. Personal and professional experiences influence

professional identity (Hammond, Cross & Moore, 2016). There is a significant role for preclinical education, relationship with mentors, and collaborations with clinical physiotherapists in forming professional identity (Mak et al., 2022). While regulatory bodies and professional associations are instrumental in professional identity formation (Drolet & Desormeaux-Moreau, 2016), there needs to be more research in this area (Mak et al., 2022). Nevertheless, these organizations are significant in the profession as they license physiotherapists, regulate the practice, promote the profession, and provide ongoing continuing development.

As part of their professional identity, physiotherapy aligns with the biomedical model of health, which focuses on the study of the body, physical treatments, and pathologies (Hay et al., 2016). Patient interaction focuses on evidence-based interventions (Twigg, 2006) in which context, social structures and lived experiences are not the foundation (Tulle, 2008). In the clinical setting, competency is measured by the number of patients treated (Walton, 2020a; Richardson, 1999), with an expectation that the physiotherapist is strong and healthy to function effectively in their role (Jorgenson, 2000; Walton, 2020b). In addition, criticism of the profession includes gender blindness across clinical practice and organizational structures (Stenberg et al., 2021).

The literature identifies various challenges in retaining mid and late-career clinicians, including burnout, time pressures, institutional barriers, and lack of formal recognition (Walton, 2020b; Gibson et al., 2010). While research explores burnout within health professions (Sanfilippo et al., 2017; Lopez-Lopez et al., 2019; Williams et al., 2017), threats are similar and noteworthy to the underlying systemic issues for physiotherapists leaving the profession (Walton, 2020a; Walton, 2020b; Walton, 2020c; Cantu et al., 2021). For example, Walton

(2020a) identified issues with professional leadership and direction, branding and awareness, clinician burnout and fatigue as specific threats to the Canadian physiotherapy profession.

Several reasons warrant further exploration of perimenopause within the physiotherapy profession. First, professional identity has focused on a community of practitioners aligning with a biomedical approach to understanding illness and determining treatment options. Second, physiotherapists work in a profession that has neglected gender in education, clinical practice, and research (Stenberg et al., 2021). Third, a significant number of physiotherapists over 40 coincided with perimenopause. Forth, there are threats to retaining mid and late-career clinicians, including physiotherapists (Walton, 2020c). Fifth, there is an identified lack of research about the aging experience of the menopausal transition across all professions and specifically healthcare providers. Finally, the physical and mental demands of the profession, the pressures on the Canadian healthcare environment, and the identified gap in the literature support the need to explore how physiotherapists currently experience and understand the menopausal transition within the workplace. This research contributes to the limited qualitative literature about the menopausal transition in the workplace and the experience(s) of physiotherapists.

2.7 Chapter Summary

The preceding chapter situated this research within health geography and positioned how the research critically engages with health and wellbeing. A literature review included the menopausal transition, engagement with health and wellbeing, and the relationships between perimenopause and work. The literature identified several factors impacting the perimenopausal experience. These findings indicate that life stressors, parental status, relationship status, and culture influence the reaction and experience of the menopausal transition. In addition, this review reveals knowledge gaps about the experience of menopause in the workplace. Finally, the

chapter provided an overview of the Canadian health care system and the physiotherapy profession as the foundation of the case study for this research.

Chapter Three: Theoretical Perspectives

3.1 Introduction

In this chapter, I describe the theoretical perspective guiding this research. First, I will begin with a description of feminism and how it frames a foundation for the theoretical approach of feminist geography. Then, the chapter concludes with an exploration of the significance of integrating sex and gender in health research, particularly in relation to the menopausal transition.

3.2 Theoretical Context

The discipline of health geography engages with various theoretical perspectives to frame the interpretation, formulation, and assessment of multiple explanations (Kearns, 1993; Kearns & Moon, 2002; Litva & Eyles, 1995). A theoretical framework provides the foundation for the construction of knowledge in research (Mertens et al., 2017). It is the structure and support for the research rationale, epistemology, and methodology (Varpio et al., 2020). Krieger (2011) emphasized that researchers risk framing questions without explicit engagement with theory, which leads to inaccurate analysis, assumptions, and conclusions. Explicit engagement with theory allows us to identify knowledge gaps, strengths and weaknesses and advances scholarly dialogue (Krieger, 2011). The role of theory in research is central to how scholars explain the geographies of health (Kearns, 1993; Litva & Eyles, 1995).

It is essential to draw on the theoretical underpinnings and apply them to health and wellbeing, specifically menopause in the workplace. Within health geography, diverse paradigms inform the research question and frame our understanding of health and wellbeing. The diversity of these paradigms, from realism (related to positivism) to relativism (associated with constructivism), contributes to our understanding of health and wellbeing (Gatrell & Elliott,

2015). I will explore four paradigms, how they inform theories in health geography, and where my research is situated within these paradigms. The paradigms are positivism, poststructuralism, structuration, and social constructionism (Gesler & Kearns, 2002). Each approach has different assumptions about reality and guides research by shaping the question and the methods to identify answers (Gatrell & Elliott, 2015).

A positivist approach emphasizes what is measurable and observable. This approach typically uses quantitative methods to determine order or patterns in a data set (Gesler & Kearns, 2002). For example, a longitudinal study in the United States used a positivist approach to understand the relationship between changes in menopausal status and the risk of depressive symptoms. This study mapped data from annual assessments of perimenopausal women (Bromberger et al., 2007). However, this approach neglects the role of human agency in understanding the lived experiences (Pile, 1993).

Poststructuralist approaches in health geography consider the underlying structures, including social, economic, and political factors that shape health (Jones, 2013). Key to poststructuralism is language, the construction of self (Heslop, 1997), the analysis of social meanings and power relations (Weedon, 1997), and words that have significant contextual meaning (Scott et al., 2008). For example, using a poststructuralist framework to interview twenty women in midlife about their reproductive health priorities identified three themes: knowledge during perimenopause, understanding options for family planning, and prioritizing their health as they age (Alspaugh et al., 2021). This approach views knowledge and power as intertwined and essential to explain the social world (Khan & MacEachern, 2021). Post-structuralists are criticized for focusing only on discourse and representation (Woodward, Dixon & Jones, 2009).

Structuration theory emphasizes that humans make their health but that societal structures shape (and are shaped by) their practices and actions (Giddens, 1984). However, this theory neglects the significance of life history as part of individual agency (Elliott, 2015) and overlooks the embodied experience (Shilling & Mellor, 1996).

Social constructionists hold that individuals and groups produce their understanding of reality (Berger & Luckmann, 1966), recognizing multiple constructed realities (Guba & Lincoln, 1994). The social constructionist approach engages bodies with their context and constructs knowledge on health and wellbeing (Gatrell & Elliott, 2015). Health and wellbeing research focuses on a person's perspective about the meaning determined by their daily interactions through experiences and observations (Umberson & Montez, 2010). The focus recognizes that the importance of understanding one's constructed reality can change, and there is not one universal reality (Guba & Lincoln, 1994; Denzin & Lincoln, 2000). To this end, the social constructionist approach lends itself to qualitative methods to hear the participants' voices and understand their perceptions and the meaning of health and wellbeing (Savin-Baden & Howell, 2013).

Direct engagement with theory enables health researchers to identify knowledge gaps, develop relevant questions and ensure quality in research design and analysis (Krieger, 2011). Theoretical engagement provides a way to explain phenomena and processes that occur in the world (Collins & Stockton, 2018). Theories inform paradigms (Guba & Lincoln, 1994), providing a set of assumptions that structure approaches to research, underpin ontology and epistemology of research, and ways knowledge is created and derived from data (Creswell et al., 2007). Within health geography, diverse paradigms inform the broader questions of identifying, classifying and enhancing health and wellbeing determinants (Gatrell & Elliott, 2015).

These paradigms guide researchers by shaping the questions about the health and wellbeing of individuals and populations and the methods used to generate answers (Gatrell & Elliott., 2015; Guba & Lincoln, 1994). However, methods do not stand alone; they are tools used to answer research questions that align with a research project's theoretical and methodological frameworks (Collins & Stockton, 2018). Social constructivism guides this research in which knowledge is value-laden, inductive, and recognized as unique based on context (Moon & Blackman, 2014). In line with the theoretical framework and methodological approach, this research uses methods that engage with feminist geography critically.

As part of this research, I required an understanding of my ontological and epistemological positions. Ontology refers to the nature and what we know about our reality (Creswell, 2014; Guba & Lincoln, 1994). In this research, the ontological question focuses on understanding the nature of perimenopause. Ontologically, every participant has a reality that is unique to them. While there are similarities between the participants, there are also many differences. These multiple realities are significant to this research as each participant tells the truth about their experience.

Epistemology refers to how knowledge is known (Creswell, 2014; Guba & Lincoln, 1994). Epistemologically, there are multiple ways to acquire knowledge and my experience, education, and professional background guide my knowledge acquisition (Richardson-Tench et al., 2018). A subjectivist epistemology (Creswell & Poth, 2018; Moon & Blackman, 2014) guides my research to reveal how a participant's lived experience(s) shapes their perception and meaning of perimenopause in the workplace.

This research applied the contextual framework by Berger and Luckman (1966) to theorize how norms, routines and patterns develop when exploring the experience of perimenopause in

the workplace. I will use feminist geographies to enhance knowledge of perimenopause in the workplace to enable this exploration. Before exploring how feminist geography frames this research, I will provide an overview of how the emergence of feminism is pivotal to this theory and research.

3.3 Feminism

Feminists argue that a society based on patriarchal systems impacts women and their experiences (Weedon, 1997). Patriarchy creates unequal opportunities for women through a system of relationships, beliefs, and values that structures gender inequality between men and women (Nash, 2020). Feminism aims to liberate women from patriarchal oppression and transform society through various socio-political movements (Maynard, 1995). The power relations as they intersect with gender underpins the feminist movement (Lengermann & Niebrugge, 1995).

Numerous approaches to feminism have developed, each representing different goals on how they understand and interact with oppression and power (Campbell & Wasco, 2000). The history of feminism has four timeframes, also known as "the four waves." The first wave started in the 1900s, focusing on equal rights for women, including suffrage and reproductive rights (Magarey, 2002). In the 1960s, the second wave, inspired by the anti-war and Civil Rights Movement, focused on the interrelatedness between women's cultural and political inequality (Hague, 2016; Nicholson, 1997; Schneir, 2014). During this wave, "the personal is political" became the focus of the equality movement (Hanisch, 2006).

Throughout the first two waves, there was growing criticism that feminism over-emphasized the experiences of white, cisgender, able-bodied, highly educated, and upper-class women (Collins & Bilge, 2020; hooks, 2000). As a new wave emerged, Black feminists argued

that diversity of identity and context must be captured in the movement to achieve equality (Crenshaw, 1989; hooks, 1984; Hankivsky et al., 2010). The concept of intersectionality (Crenshaw, 1989) shifted the feminist movement to include multiple forms of discrimination and emphasized the intersection of contextual factors, including class, religion, culture, race, gender, and age (Collins, 1998; Collins & Bilge, 2020). "Feminism as a movement to end sexist oppression directs our attention to the systems of domination and the inter-relatedness of sex, race, and class oppression" (hooks, 1984, p. 31).

The fourth wave of feminism continues to expand our understanding of intersectionality by engaging beyond the binary identities of male/female (Zimmerman, 2017). `Intersectionality has provided a paradigm (Bilge, 2010), a theory or framework (Carbin & Edenheim, 2013), a methodology (Naples, 2009), or a political movement (Carbin & Edenheim, 2013). Unfortunately, these various uses of intersectionality have created confusion about what it does (Davis, 2008). The emergence of intersectionality from Collins & Bilge (2020) guided my understanding of feminism as a mechanism to analyze the complexity of lived experience(s). Multiple identities interact in ways to influence each other, and it is through these interactions that we start to understand social and gender inequalities (Collins & Bilge, 2020).

Scholars also showed how gender differences frame a hierarchy among the dichotomies of public/private, mind/body, abstract/concrete, and reason/emotion (Benhabib & Cornell, 1987). Deconstructing these dichotomies, recognizing intersecting identities, and the expanding gender fluidity impacted feminist thought, activism, and approaches (Campbell & Wasco, 2000). This wave has embraced the public discourse and brought feminism outside the academy by engaging social media and situating the discourse of power into everyday lived experiences (Chamberlain,

2017). While technology has been the foundation of the movement, opposition to sexual harassment and violence against women has fueled this wave (Peroni & Rodak, 2020).

The waves of feminism coincided with a shift in society's attitude about women's engagement in the economy (Oberhauser, 2017), leading to a growing increase of women in the labour market (Johnson, 2011). However, a gender divide defined the types of occupations for women, particularly in health care (Witz, 1992). In some health careers, women were denied access to apply and earn a degree in that discipline (Adams, 2005). Moreover, as women entered the economy, they held support roles in health careers instead of leadership positions (Riska, 2001). Even today, elements of this gender divide permeate health care as institutions focus on inclusive policies (Lindsay, 2005) to ensure the health workforce reflects the populations they serve (Boelen, 2016).

Canadian health educators have increasingly focused on gender inequities in clinical practice, research, and education. Although institutions design policies and legislation to address inequities and enhance diversity (Lee, 2019), the power of patriarchy in the work environment is hidden and often neglected (Valentine et al., 2014).

Gender equity researchers point out that institutional programs and policies alone are inadequate in addressing these disparities (Ahmed, 2007). An example at Columbia University focused on more flexible career tracks, parental leave policies, increased childcare support, and on-site breastfeeding rooms. Yet, these initiatives failed to increase women's tenure or leadership opportunities (D'Armiento et al., 2019). In addition, evidence points to addressing everyday cultural practices as a barrier to women's advancement and success in the workplace (Burgess et al., 2012; Hoyt & Murphy, 2016; Rudman & Glick, 2001).

Medicine mirrors broader patterns of gender inequities in education and health care (Carr et al., 2018). Scholars propose several social, institutional, and individual-level factors, including women's roles in health care; women's lack of mentors and role models; hostile climates, physical, sexual, and verbal harassment; and exclusion from dominant medical culture (Ahmed, 2007). These factors affect the physiotherapy community (Hammond, Cross & Moore, 2016).

The changes in feminism have challenged our assumptions about power and oppression while creating a dialogue to engage gender as an analytical category (Haraway, 1991). An understanding of feminism is essential for this research because the multiple contexts that influence gendered experiences reflect an attempt to remain mindful of the many intersecting factors that influence the experience of perimenopause in the workplace. Within this context, I will introduce feminist geographies as the theoretical framework that informs this research.

3.4 Feminist Geographies

Until the 1970s, the discipline of geography was void of research, education, and discussions about gender (Nelson & Seager, 2008). Rose (1993) spoke about the erasure of feminist work and gender within geography, and the default language and analysis was a masculine lens. With the growth of feminism, the academy shifted its hiring and admissions processes to increase female students and faculty, and courses began to include a gender lens. A journal was established in 1994 to provide a space for scholarly literature on gender and geography (Gender, Place and Culture) (Brown & Staeheli, 2003). The increased presence of gender across the discipline also led to the emergence of Feminist Geography, focusing on exploring social differences through geographic research (Moss & Falconer, 2007). Bringing a feminist perspective to key geographic concepts of space, place, and scale contributed to

understanding power relations and how to destabilize them (McDowell, 1993; McDowell & Sharp, 1997).

Feminist geography recognizes that gender situates individuals differently in the world and, subsequently, will experience "place" differently based on gender (McDowell, 1997). Gendered relationships of power construct place (Rose, 1993). Geographers engage with the concept of place as contested, multiple, layered, and constructed, particularly in relation to power (Staeheli & Martin, 2000; McDowell, 1993).

Feminist geographers use methods to interrogate power-laden processes of meaning to disrupt dominant narratives of people and places (Domosh & Seager, 2001; Domosh, 1998). Understanding power to include race, class, gender, and sexualized power (Sharp, 2009), feminist geography disrupts the gender binary by exploring the multiple intersections of identity, knowledge, power, and agency, particularly regarding health and wellbeing (Valentine, 2007). Tools used by feminist geographers for analysis disrupt the gender binary by asking why individuals perform their roles, exploring the diversity of voices through an intersectional approach, and seeking to understand other identifiers of individual struggles and motivations (Mollett & Faria, 2018; McDowell, 1999).

Understanding gender relationally means that we must understand the mechanisms by which sex and gender mark bodies. Feminist geography engages with intersectionality by conceptualizing power and agency to encompass sexism, racism, ageism, heterosexism, and other axes of oppression in their complex interactions (Crenshaw, 1989). Analyzing how power intersects across identity is critical (Collins, 1998), while intersectionality creates a framework to explore these relationships between and across identities (Mollett & Faria, 2016; Lykke, 2010). Intersectionality acknowledges that people live multiple, layered identities as members of

various communities - where gender is one social relation among others (Mollett & Faria, 2013; Crenshaw, 1993, 2017).

Feminist geography uses a gendered lens to examine how relations are created through interactions with other markers of social difference (e.g., class, race, ethnicity, age, and (dis)ability) to shape access to and control of resources within and beyond the household (McDowell, 1999). Feminist geography articulates the significance of multiscale analysis and the integration of social and biophysical analysis of power relations and the environment (McDowell, 1997). Additionally, feminist geography focuses on how gender is experienced, contested, and reinforced within households and communities (Domosh, 1998; Zavattaro, 2019; Truelove, 2011).

Collins & Bilge (2016) proposed using feminist concepts of intersectionality to foster the exploration of multiple intersections of identities, knowledge, power, and agency around aging in place. They maintain that conceptualizing gender to mean 'men versus women' provides a superficial understanding of the complex debates about power in the work environment, specifically health care settings. Finlay (2021) uses insights from feminist geography to explore the social construction of gendered conceptualizations in aging and how they influence what we value and do not value. While these studies engage important debates about aging as an identity, they do not capture health and wellbeing. As such, we need to determine the impact of aging and perimenopause on people in the work environment, specifically in health care settings. Thus, the effects of aging in the workplace continue to be a challenge for scholars interested in conceptualizing human agency over multiple and divergent scales.

Intersectionality provides a theoretical framework to enhance geographical concepts about the relationship between and across identities (Valentine, 2007). It focuses on power to

deepen the exploration of the lived complexities of aging and perimenopause beyond gender. Intersectionality also extends to the work setting, and the notion of intersectionality as a construct can yield significant insights into the joint consideration of age and gender in the workplace. These relationships can shape identities, which may influence work perceptions and outcomes (Cleveland et al., 2017; Crenshaw, 1990; Monrouxe, 2015; Tsouroufli et al., 2011).

Feminist geographers develop a relational understanding of scale, recognizing that they cannot disconnect national and regional policy from the household and community level (Sharp, 2009). Feminist geography conceptually links how operations at the global level become embodied in individual lived experiences (Dyck, 2005; Blidon & Zaragocin, 2019). At the same time, feminist geography is acutely aware that any interaction within the local scale always operates within broader socioeconomic and historical contexts (Dyck, 2005). Understanding gender relations in space and place across scales is central to feminist geographers (McDowell, 1997).

There is limited attention to how contextual experiences (e.g., employment opportunities, family responsibilities, political systems) play out temporally across the life course, with implications for health and wellbeing (Crooks, Andrews & Pearce, 2018). Gender is a mix of social and biological factors that interact to shape access and availability to resources across the life course (Moen, 1996; Umberson, Lin & Cha, 2022). Therefore, exploring gendered differences in wellbeing as part of aging is essential for policy and practice (Graham & Chattopadhyay, 2013).

Drawing on feminist geography sheds light on how relations of power and inequality over the life course shape health and wellbeing as part of aging. Over the life course, these experiences inform different aging realities for men and women. Examining life course

experiences can further expose how gendered relations of power and inequalities experienced over time shaped contradictory experiences of wellbeing as part of aging and the menopausal transition (Finlay, 2021)

This research uses feminist geography to explore the co-existence of identities (i.e., age, gender, class, race) as part of health and wellbeing for persons experiencing perimenopause in the workforce. (Mollett & Faria, 2013). This research elucidates the mechanisms of power and uses analytical tools to register how people adapt to the environment to meet their individual needs (Manion & Shah, 2019). The research also seeks to destabilize gender as a central analytical category and emphasizes other axes of power and difference (i.e., race, sexuality, class, age, and place) to construct gender (Crenshaw, 1989; Mollett & Faria, 2013; Nightingale, 2006).

3.5 Aging within Feminist Geography

While Feminist Geography engages diverse population subgroups (e.g., women, class, race), little work has considered how age acts as another important category of difference (Allen, 2016; Loe, 2011). Aging is a form of identity considered temporal concerning gender, race, and sexuality (Loe, 2011). While aging is a dynamic process (Segal, 2013; Toni & Calasanti, 2006; Sandberg, 2013), it is not explicitly the focus of feminist geography (Finlay, 2021).

This research will contribute theoretical insights into perimenopausal experiences by capturing age as another identity of difference and power structure (Krekula, Nikander & Wilinska, 2018). Theorizing more explicitly how different actors socially construct age relations expose sources of age inequalities and, ultimately, provides evidence for policy recommendations that impact across space and time (Skinner et al., 2015). To date, the literature related to aging has primarily focused on "older people" as a distinct social group and has

neglected how the "middle-aged" population experiences their aging process (Enßle & Helbrecht, 2021). This research will explore the aging process through the experience of the "middle-aged" population with particular attention to the spaces and places of everyday life (Dyck, 2005).

Aging in the workplace is created, constructed, and contested across scales (Sippli et al., 2021). Feminist geography recognizes the relational nature of aging in the workplace and is affected by and reflected in embodied practices and lived social relations (McDowell, 1999). Informed by feminist geography, this research critically explores the sociocultural relation of aging in particular places at multiple scales, which help to (re)produce and challenge inequality (Finlay, 2021; Lewis & Buffel, 2020) in the workplace. It also considers the production of inequalities and the sites of (re)production of social differences (Elmhirst, 2011). This research contributes to advancing scholarly work based on the relationship of aging through feminist geography.

3.6 Menopausal Transition and Feminist Geography

Health geographers seek to understand the role of place as a determinant of healthy aging and how space and place influence the wellbeing of aging populations (Cutchin, 2007). For most women, one of the experiences of aging is the transition to menopause. However, this normal part of aging is often experienced in isolation contributing to the silence surrounding menopause in broader society (Greer, 1992). In addition, people seldom speak about their experience of the transition to menopause with each other or with outsiders (DeLeyser & Shaw, 2013), limiting the social understanding of menopause in broader society. These factors collectively contribute to the limited exploration of menopause within health geography (DeLeyser & Shaw, 2013).

The literature on menopause also lacks consistent theoretical underpinning (DeLyser & Shaw, 2013). Social theory helps to generalize knowledge, develop critical reflection, and complement biomedical, epidemiology and health services work (Herrick, 2016). However, a more thorough consideration of theoretical applications is needed to better understand the experiences of menopause across the life course (DeLyser & Shaw, 2013; Kleinman et al., 2013). Health geographers can contribute to these discussions by engaging with theory to understand population distributions of health, disease, and health care (Gatrell & Elliott, 2015; Luginaah & Bezner-Kerr, 2015). Guided by theory, health geographers develop questions rooted in context to contribute to a deeper understanding of how geographies shape disease diffusion, health risk perceptions, determinants of health and health inequalities (Rosenberg, 2014), including the experience of menopause across the life course (Bhakta et al., 2018).

Gendered experiences across the life course shape the wellbeing of people experiencing perimenopause. This research brings new insight regarding the spatial-temporal (re)production of gendered inequalities and how place-based processes, over time, produce unique wellbeing realities for people experiencing menopause (Jack et al., 2018). Furthermore, paying attention to micro and macro temporalities enables exploring how particular events, transitions and periods over the life course have immediate and enduring impacts on gendered health and wellbeing in menopause (Marshall & Katz, 2012).

I use feminist geography as an analytical lens to study and theorize how gender and space are in daily and political life (Massey, 2013). Through feminist geography, I explore the production and conceptualization of space, place and gender through hierarchical social relations that are dynamic and always contested (Massey, 2013). Feminist geography situates gender and the transition to menopause while examining the experience in a health workforce setting. This

lens highlights the complex interconnections and the flows of power that arise from networks with profound effects on women's lives everywhere. Feminist geography can underscore how knowledge and narratives around menopause are circulated (or not circulated) to society (Domosh & Seager, 2001; DeLyser & Shaw, 2013).

The experience of menopause is shaped and constrained by the broader socioeconomic and political processes that are constantly interacting at the macro (national) and meso (institutional) levels (Jack et al., 2018). The interaction between the macro-level determinants (i.e., national institutions), meso-level factors (i.e., sociocultural relationships, resource allocation), and micro-scale processes (i.e., coping strategies, resources) (Jack et al., 2018) shapes the menopausal experience of health and wellbeing in the workplace. Engaging feminist geography in this research will create space to question the relations between social systems to understand everyday embodied lives across the lifespan, focusing on an under-researched time of middle age. Feminist geography examines how the roles and responsibilities (re)shape gendered advantages and disadvantages that can become reconfigured over time and space in unexpected and contradictory ways (Mollett & Faria, 2013).

3.7 Integration of Sex and Gender Considerations

This research sought to explore the gender dimensions of health and wellbeing during the transition to menopause within the work environment for physiotherapists. Sex and gender were key considerations throughout the design, data collection, and analysis (Williams et al., 2021). This research used the language “persons experiencing the menopause transition” to include a spectrum of gender identities and followed the Canadian Institute for Health Research guidelines on integrating sex and gender (CIHR, 2018).

Navigating sex and gender in research is complex (Moseson et al., 2020) and requires intentional focus throughout the research process (Gahagan et al., 2015; Johnson et al., 2014). Sex and gender represent distinct ideas and are not interchangeable concepts (Short et al., 2013). Sex refers to the genetic, physiological, and biological characteristics that traditionally distinguish men and women (Caplan & Caplan, 1997). Gender refers to the socially constructed characteristics, roles and identities of girls, women, boys, men, and gender-diverse people (Short et al., 2013; Butler, 1990). Gender influences how people perceive themselves and each other, how they act and interact, and the distribution of power and resources in society (CIHR, 2021). I acknowledge that the categories of 'men' and 'women' are unstable and constructed categories receiving meaning within a normative heterosexual framework (Butler, 2004; Öhman, Eriksson, and Goicolea, 2015).

In this research, the question and objectives focused on the individual's experience of perimenopause as valid, meaningful, and authentic. The research, guided by feminist geography, shed light on how relations of power and inequality shape health and wellbeing as part of gendered aging in the workplace. This theoretical perspective advanced the dialogue surrounding menopause in the workplace while including diverse experiences, thoughts, and ideas. In addition, reflexive thematic analysis created the platform to understand the social construction of meaning across the data as articulated by the participants.

3.8 Chapter Summary

The chapter began with an exploration of the diverse paradigms that inform research questions in health geography and how this research will engage with social constructionism to explore participants lived experiences, perceptions and meaning of health and wellbeing. The changes in feminism provided context and background to the many intersecting factors that

influence the experience of perimenopause in the workplace. Feminist geography as the theoretical framework informs this research to broaden understanding of invisibility and power present throughout the menopause experience in the workplace (England et al., 2019; Beck et al., 2018; 2019). This framework provides a foundation from which to question and dismantle assumptions about the experience of perimenopause. Further, feminist geography is necessary for understanding how people interpret their world, their experiences, and how others understand them (Mollett & Faria, 2013). The chapter concluded by exploring the significance of integrating sex and gender in health research, particularly concerning the menopausal transition.

Chapter Four: Research Methodology

4.1 Introduction

This chapter provides an overview of the research design and methodological framework used to address the research objectives. In addition, this chapter discusses qualitative research methodology and Stake's constructivist approach to a case study. This section describes the research context, ethical considerations, sampling, and recruitment. Next, the chapter explains the data collection methods (i.e., interviews and field notes), followed by the data analysis framework using reflexive thematic analysis guided by Braun and Clarke (2006, 2020). Finally, the chapter concludes with a reflection on methodological rigour and researcher positionality.

4.2 Qualitative Research Design

This research used an exploratory research design (Stebbins, 2001) to understand a topic with limited investigation and to recognize the lived experience(s) of participants (Polit & Beck, 2012). This design supports the detailed exploration of a phenomenon (Creswell & Poth, 2018). This research aimed to understand the gendered dimensions of health and wellbeing as part of the perimenopausal experience in work.

The research design has steps that build on each other. First, with research objectives, the process encompasses an exploration of the ontological and epistemological foundations. They were followed by an alignment with the theoretical perspective before examining the methodology and engaging with methods (Creswell & Poth, 2018; Gatrell & Elliott., 2015; Guba & Lincoln, 1994). Chapter Three outlined the alignment of this research with the first four steps of the process by describing the research objectives, ontology, epistemology, and theory.

The choice of methodology dictates the methods to be used in the research. Methods do not stand alone; they are tools used to answer research questions that align with a research

project's theoretical and methodological frameworks (Collins & Stockton, 2018). This research uses a case study methodology to explore the perimenopausal experience in the work environment. The following section will outline additional background on the rationale for using a case study in this research.

4.3 Case Study

Case study methodology explores complex issues and phenomena in real-life settings (Yin, 2009) by many disciplines, including health geography, education, and psychology (Creswell & Poth, 2016). In a case study, the researcher collects data and interprets the meaning of the data through analysis (Stake, 1995). This interpretation throughout the analysis contributes to an in-depth understanding of the phenomena. The analysis continues within the data collection process to explore the research question and collect relevant data (Stake, 1995).

A case study allows researchers to focus on the context of a case (Baxter & Jack, 2008; Stake, 1995), although the aim is not to produce generalizable findings (Stake, 1995). Instead, researchers use a case study to focus on exploring and examining a particular case to develop a deep understanding of that case, which Stake refers to as "particularization" (1995).

A case study aims to support researchers in developing an in-depth understanding of a case (Baxter & Jack, 2008; Stake, 1995), and the researcher gains a deep awareness of the phenomena by focusing on the context. Case studies provide the framework for researchers who seek answers to "how" and "why" questions (Baxter & Jack, 2008; Stake, 1995; Yin, 2009). These questions lead to findings that inform a deeper understanding of the topic and explore phenomena with little information and knowledge (Gerring, 2004).

Given the lack of knowledge on menopause in the workplace, a case study provides the opportunity to investigate a distinct phenomenon with limited research (Jack et al., 2021;

DeLyser & Shaw, 2014). In addition, using a case study allows for considering how various environments (e.g., social, cultural, physical, political) inform health and wellbeing, why inequalities exist, and how these factors vary by population (Stake, 1995). The research question for this dissertation aligns with the case study methodology as it explores a distinct phenomenon (i.e., perimenopause in the workplace) with limited research (Verdonk et al., 2022).

4.3.1 Types of Case Studies

There are many approaches to case studies, including Robert Stake (1995) and Robert Yin (2009) as two key leaders in this field. Yin (2009) frames a case study from a positivist approach and uses both qualitative and quantitative methods. Yin (2009) believes that case studies should maintain integrity through construct validity, internal and external validity, and reliability (Yin, 2009). In contrast, Stake (1995) takes a constructivist approach guided by qualitative methods. Researchers should consider the phenomenon's interrelationship and context while ensuring that observations guide the data collection (Stake, 1995). In addition, Stake's qualitative case study is flexible in design, allowing researchers to modify based on their findings with the research question. This research aligns with Stake's case study approach.

Stake's approach has three types of case study design: intrinsic, instrumental, and collective (Stake, 1995). An intrinsic case study explores the case as the object of study, developing an understanding of the specific case and not how a phenomenon works or occurs (Stake, 1995). In comparison, an instrumental case study aims to develop an in-depth understanding of a specific case to improve knowledge of the topic or phenomenon beyond the specific case. The researcher embraces the case to understand something beyond the specific case (Stake, 1995). A collective case study is the selection of multiple cases in an instrumental case study requiring coordination among them (Stake, 1995).

Stake's approach to case study has a natural alignment for this research and allows the focus to be through an instrumental case study design. This type of case study is appropriate because this research is interested in understanding how physiotherapists experience their work through the transition to menopause. An in-depth study of how physiotherapists experience menopause in their work environment will contribute to our understanding of structural support(s) in the workplace. In addition, the findings of this case study (i.e., Canadian perimenopausal physiotherapists) will add knowledge to understanding the relationship between gender, aging, and menopause in the workplace.

4.4 Research Context

This research takes place in Canada, which has a publicly funded health care system with a division of roles and responsibilities between the federal government and ten provincial and three territorial governments. The delivery of health and social services is part of the provincial responsibilities. At the same time, the federal government is responsible for setting national principles, providing financial support to the provinces and territories and delivery of care to specific groups, including First Nations people, Inuit, and members of the Canadian Armed Forces (Dhalla & Tepper, 2018; Health Canada, 2020).

In 2006, over 1 million people in Canada were working in 30 health professions, representing 6% of the workforce (Statistics Canada). There is a growing recognition of the importance of rehabilitation teams in the health care system (Bourgeault et al., 2019; Hudon et al., 2014). In addition, the pandemic impacted health care delivery and strengthened the growing importance of rehabilitation services as part of recovery from any infectious disease (Landry et al., 2020). Physiotherapists are part of these rehabilitation teams, including occupational therapy, audiology, and speech-language pathology.

In Canada, physiotherapists are a regulated health profession and provide health care to assist patients in managing and preventing acute and chronic disease and injury (CPA, 2012). Physiotherapists play a vital role in all health sectors, from acute to long-term care, with training to help prevent and treat injury, illness, or disability. There are over 26,019 physiotherapists licensed to practice in Canada (an increase of 2.9% since 2019), with 90% working in direct care, 76% identifying as women and 53% over the age of 40 years (CIHI, 2021). In addition, physiotherapists register in one of ten provincial and territorial regulatory bodies offering services in hospitals (35%), community settings (60%), long-term care (2%), university (1%), and other settings (1%) (CIHI, 2021).

According to Walton et al. (2020), the physiotherapy profession has predominantly been able-bodied, cis-gendered, and white. Criticism of the profession focuses on maintaining a system and structures of racism (Vazir et al., 2019). However, there is significant work taking place to expose these biases and address the gaps in recruitment, admissions, and education programs within health care, specifically in physiotherapy (Brascoupé et al., 2009; Gasparelli & Nixon, 2018; Gibson et al., 2010; Nixon, 2019).

This research occurred during a global pandemic when healthcare professionals experienced increased pressure at work. They are putting in extra hours, treating infected patients, physically distancing themselves from their families, and managing changes in public health measures (Quigley et al., 2021). As part of COVID-19, the scope of practice for physiotherapists changed in six provinces, with four provinces performing COVID-19 testing and administering COVID-19 vaccines (Quebec, Ontario, Manitoba, Saskatchewan) and two provinces administering COVID-19 vaccines (Alberta and BC) (CIHI, 2019). The pandemic highlighted the significance of their role across the continuum of care, from the intensive care

units to beyond discharge to living at home and in the community (Dean et al., 2020). The trajectory of physiotherapy grounded in evidence creates an opportunity for the profession to continue to grow within the healthcare system (Dean et al., 2020).

4.5 Ethical Considerations

The research protocol was reviewed and approved by the University of Waterloo Research Ethics Committee (ORE#43019) in March 2021 (see Appendix A). Research participants gave written and verbal informed consent before participating in the research. The consent forms outlined research objectives, participation requirements, expected outcomes, and the research benefits. In addition, participants emailed a signed consent form (Appendix B) and provided verbal consent at the start of the interview.

Participation in the research was voluntary, and participants could withdraw at any time without penalty. In addition, participants were encouraged to ask questions and informed that they could stop or take a break at any time during the interview.

The researcher ensured the confidentiality and privacy of the research participants by storing all data in a password-protected computer. Only the researcher had access to the data. All information gathered from the research participants was confidential. The information provided by participants was used only for this research.

Each participant was assigned a non-identifiable code, and all identifying information was confidential. The list of participant names was kept separate from the data collected, and only the doctoral student had access to codes linked to participant identities. Likewise, participants' contact information was stored separately from any research data.

4.6 Sampling and Recruitment

This research explored the experience of perimenopause in the workplace for physiotherapists in Canada. The sample size was not chosen for representativeness but rather to include a variety of perspectives to develop an in-depth understanding of this case. Purposeful and snowball sampling strategies guided the recruitment of participants. The research started with purposeful sampling. During the interviews, participants reflected on other physiotherapists who may be interested in this research (Creswell & Poth, 2018; Polit & Beck, 2012) to ensure participants reflected the diversity within the profession. In addition, participants shared research information with colleagues and through social media. Recruitment for participant interviews took place from March to August 2021 (five months).

As a registered Occupational Therapist (in Nova Scotia) and through national volunteer work, the doctoral student has established connections with members of the physiotherapy community. This professional network shared information about the research through social media, referred potential participants, and spread information via word of mouth. Participants were not solicited directly for this research. However, recruiting participants was purposeful and met the following inclusion criteria:

- Registered as a licensed physiotherapist in Canada
- Employed in Canada as a physiotherapist
- Persons experiencing perimenopause aged between 35 and 60 years who are living the transition from menstruation through menopause and beyond
- Available to meet for an interview online
- Willing to share experiences in English
- Able to give informed consent for participation

An important aspect of recruitment was the ability to gain access to the potential participants of the research (Creswell & Poth, 2018; Stake, 1995). The national physiotherapy organizations (i.e., provincial colleges and regulatory bodies) received emails to share information about the research and seek support in recruiting participants from their membership. In addition, these organizations distributed information about the research to members (see Appendix C).

4.7 Data Collection

Qualitative researchers use data collection tools, including interviews, focus groups and observation (Creswell & Poth, 2018; Stake, 1995), guided by theoretical and methodological frameworks (Collins & Stockton, 2018; Elliott, 1999). Therefore, following ethics approval, interviews, and field notes, including observations from interviews, were used to collect data for this research.

4.7.1 Interviews

An interview guide was developed based on the research question and objectives (Appendix D). Questions explored health and wellbeing, the menopause transition and aging in the workplace guided by constructs within feminist geography. Additional probing questions assisted in further clarification. The interview guide was tested on a perimenopausal colleague to identify any confusing terminology or concerns about the questions. The interview guide was refined based on this feedback.

The interviews were in English and lasted between 45 and 80 minutes. The interviews concluded when no new information or themes emerged from the discussions (saturation). Field notes supplemented the audio recordings.

As the interviews were conducted from May to August 2021 during the global pandemic, the interviews took place using a virtual video platform (Cisco Webex) and only the audio recording was maintained.

4.7.2 Field Notes

Field notes throughout the research included documenting ideas, reflections, and observations. Field notes are a standard data collection strategy in qualitative research (Creswell & Poth, 2018; Stake, 1995). The researcher recorded observations of participants during interviews, thoughts throughout the research, and documentation of research-related activities. After each interview, the researcher documented how they felt the interview went, including their performance as an interviewer, how the participant responded, and how the data could answer the research question. The researcher also documented discomfort and impressions about how their personal and professional positionality influenced data collection. The field notes documented decision-making, challenges, and methodological issues throughout the data collection process (Stake, 1995). The field notes served as a data source, audit trail, and place to engage in reflexivity throughout the research journey. Therefore, NVivo analysis included the field notes.

4.8 Data Analysis

Interpretation of the data reflects the researcher's positionality and the theoretical and methodological frameworks guiding the research. The analysis focused on listening to conflict, observing the multiple perspectives, and contextualizing the narratives (Ley & Mountz, 2001). In addition, the analysis attended to the complexity of the data in keeping with the methodological focus.

To understand the data and to answer the research question, the researcher categorized the data through a coding process (Crang, 2005) guided by reflexive thematic analysis (Braun & Clarke, 2006; 2021). The focus was to organize the data into categories, each interview was analyzed separately, and results were brought into the conversation to identify themes discussed in Chapters 5, 6, and 7.

Organizing and interpreting data is an important task, and "one of the main threats to ensuring qualitative validity is the misinterpretation of meanings expressed through interview conversations" (Baxter & Eyles, 1997, p. 509). Therefore, organizing and interpreting the data is based on "participant concepts" rather than "theoretical (researcher-derived) concepts" (Rose & Johnson, 2020). Furthermore, this approach to categorizing data fits with feminist geography, as it does not seek to override the reflexivity and knowledge of the research participants (Crang, 2005).

4.8.1 Reflexive Thematic Analysis

The data from the qualitative interviews were analyzed using reflexive thematic analysis (Braun & Clarke, 2006; 2021). As a qualitative researcher, I recognized that the analysis and themes can only be partial and aim to capture only some of the phenomenon (Tracy, 2010). Therefore, the analysis took an inductive approach, and I worked with the data from the bottom-up (Braun & Clarke, 2014) by exploring the participants' perspectives. Through analysis, I sought to identify patterns across the data to tell a story about the experience of menopause in the workplace. I used the six phases of Braun and Clarke's (2006; 2021) reflexive thematic analysis. The phases were fluid throughout the analysis.

Data familiarisation and writing familiarisation notes (Phase 1)

Immersed in the data throughout the research, I collected, conducted, and transcribed the interviews, allowing me to engage with the data across time. I engaged with the participants, built rapport, explored their experiences, and listened multiple times to the interviews as part of the transcription process. Transcribing the interviews verbatim helped me to listen to every word, pause and expression. In addition, this process allowed me to identify things that I should have noticed in the interviews or were less noticeable when I was the interviewer.

Upon completing the transcription, I read the transcripts four times, allowing me to reflect on the words and remove the individual voices. Then, I used my journal to reflect on my reaction, each participant's story, and the research question.

As I became familiar with the data, I made notes before starting to create initial codes in the transcripts. At this point, I read the transcripts in Microsoft Word and took notes electronically on the side of the document in track changes.

In this phase, I used deductive codes to capture themes corresponding with the interview questions, existing literature, and concepts, and inductive codes to explore issues emerging from the transcripts (Braun & Clarke, 2021). Themes and sub-themes emerged as part of the coding manual. The process of coding and developing themes included descriptive and interpretive elements (Braun & Clarke, 2012). The descriptive element focused on the participant's words. At the same time, the interpretive element drew on less evident patterns to develop ideas from the participants' experiences and consider their relationships alongside the literature (Braun & Clarke, 2006).

Systematic data coding (Phase 2)

Moving through the data, I continued to code each transcript by focusing on meaningful data. I focused on how the participants shared their experiences. Through this process, I returned to coding. I identified latent coding as I explored the deeper meaning of the participant's words. I continued to journal my experiences to ensure that I focused on the data and not my personal experiences.

Generating initial themes from coded and collated data (Phase 3)

I established themes from the data when coding was complete for all interviews. This process started by collating codes and organizing them into areas commonly expressed by participants (see Appendix E). Next, I reviewed my journal, where I noted standard codes that should be brought together into a sub-theme or potentially a theme. Finally, I started to visualize patterns with the data. While I used NVivo for the coding, I also used thematic maps of the codes outside the computer screen. Related codes were collated and developed into a potential theme and sub-theme.

Developing and reviewing themes (Phase 4)

The next phase of developing themes was iterative and required returning to the codes and the research objectives. Again, the back-and-forth process helped visualize the emerging patterns and start to map the quotes which support the themes. I continued experimenting with visual thematic maps as a tool to see the connections and relationships between different ideas and patterns.

I started writing ideas as part of the analysis (Braun & Clarke, 2012), which helped adjust the themes while noticing gaps in my analysis. Throughout the process, I continued to work with the research objectives, which helped identify critical themes according to their relevance and the

predominance of the same theme across participants (Braun & Clarke, 2014). This iterative process of continually identifying themes and making linkages led to saturation, whereby the data described the themes (Guest, Namey, & Chen, 2020).

Refining, defining, and naming themes (Phase 5)

Continuous refinement of the data required time presenting initial ideas to colleagues and my Ph.D. committee to receive feedback and continue to refine the themes and subthemes of this research. Again, participant quotes were critical to connect the data and the theme.

Writing the report (Phase 6)

Writing the dissertation and revisiting the earlier phases ensured that the findings represented the data and met the research objectives. Next, I returned to the literature to make connections with the data. Finally, I returned to the original transcripts to ensure that my interpretation of their words was credible.

4.9 Methodological Rigour

To ensure trustworthiness within the analysis and findings of my qualitative research, I wanted to demonstrate rigour in the process (Noble & Smith, 2015). Therefore, four criteria guided this research: credibility, dependability, transferability, and confirmability (Lincoln & Guba, 1985; Baxter & Eyles, 1997).

First, credibility was critical to ensure the findings reflected the truth as reported by the participants (Baxter & Eyles, 1997). The researcher adequately provided an accurate summary of the participants' perspectives. In addition, I identified participants through purposive and snowball sampling to ensure that I captured a range of perspectives from multiple geographic locations and scopes of practice. I also developed a rapport with participants, which was important as all interviews were conducted virtually (e.g., create a safe space). Finally, I used

peer debriefing with colleagues and my academic supervisor to discuss the interpretation of the results.

Second, enabling strategies to develop confidence in the ability to repeat the research and that the findings would be similar (Lincoln & Guba, 1985). The careful implementation of the research design, data collection and analysis were outlined in the approved ethics application and research proposal to ensure the dependability of the findings. I also focused on the accuracy of the transcription process and coding of the themes to enhance the analysis and interpretation of the data by accurately capturing the respondents' thoughts and lived experiences (Creswell, 2014; Lincoln & Guba, 1985; Miles, Huberman & Saldana, 2018). During the research process, I maintained field notes by recording observations and reflecting on the interviews to track the process (Lincoln & Guba, 1985).

Third, I focused on the transferability of the findings to another setting or context (Lincoln & Guba, 1985) by conducting interviews until no new information or themes were observed (known as saturation). Saturation helped to identify the possible perceptions and experiences related to menopause in the workplace that could be similar in different work settings (Morse, 2015). Throughout this research, I provided expanded descriptions of the research setting and the theoretical framework guiding the question to increase understanding of the types of geographical contexts where results may be applicable.

Finally, confirmability is a critical element within qualitative research where findings represent the collected data and not the views or values of the researcher (Lincoln & Guba, 1985). The field notes became part of the journaling process, creating a process of ongoing reflection to situate me in the research process while maintaining objectivity and becoming aware of my personal and implicit biases that may impact the research findings (Noble & Smith,

2015). Journaling created a space and time where I noted my ideas and feelings throughout the research process (Creswell & Poth, 2018). Maintaining a journal ensured that I was reflective and accountable in my role as a researcher. In addition to journaling, I also met with methodological experts and my academic supervisor to ensure that I was rigorous in my analysis.

4.10 Researcher Positionality

It is important to note how my identities intentionally and unknowingly influence my research. I identify as a white, settler, middle-class, non-disabled, anglophone, cis-gendered, university-educated, perimenopausal woman. I grew up in an English-speaking, rural community in Cape Breton, Nova Scotia, raised by parents who worked as public servants. I believe these identities impact how I see the world and, therefore, how I conduct my research. I work hard to understand my identity and role in society by actively engaging in work to unlearn and challenge the systems of white privilege.

Despite these efforts, there will always be limits to which I can personally identify and understand these systems and structures and ways to challenge, disrupt and dismantle them. The overarching implication of my social identity is that I will likely reproduce and reinforce white/Eurocentric/colonial narratives.

I bring this forward as part of my positionality as a researcher because this worldview influences how I ask questions, the relationships I form, the data analysis, and how I continue to engage with the research. There are gaps partially attributed to my identity and positionality, which will be discussed later in this dissertation. It was essential to engage in a robust process of reflexivity as "active acknowledgement and explicit recognition that this position may affect the research process and outcome" (Berger, 2015, p. 220).

My research interest stems from conversations with colleagues about their journey through perimenopause and struggles in their work environment. As a perimenopausal woman, I identified with some literature and participants' stories. Through this research, I realized I did not have much personal or professional knowledge about menopause. While I am a health professional, I have not had conversations about perimenopause in my clinical practice, education, or administrative positions. However, I was aware of my position as an occupational therapist, academic, Ph.D. student, and perimenopausal woman.

Throughout this research journey, reflexivity has been an essential foundation in all process components and was significant throughout the data analysis. Reflexivity comprises the "ability to notice our responses to the world around us, other people and events, and to use that knowledge to inform our actions, communications and understandings" (Etherington, 2004, p. 19). My Ph.D. journey continues to be a process of learning and unlearning. I strive to build relationships based on respect, trust, and inclusion while creating safe spaces for participants to share their experiences and perspectives to help guide us to a more equitable and just world.

4.11 Chapter Summary

The chapter described the process used in this research, including the research design, methodology, context, ethical considerations, data collection and analysis. The qualitative research design allowed individual stories to explore perceptions and meanings around perimenopause, health, and wellbeing in work environments in Canada. The purpose of describing the research context was to situate the research and provide the place-based characteristics that are relevant to this research. Data were analyzed using a reflexive thematic analysis framework (Braun & Clarke, 2006). The subsequent chapters will present the findings of the research.

Chapter Five: Exploring Being Well at Work

"There's no pause button at work" (P09)

5.1 Chapter Outline

The findings from this research will be presented in three separate chapters (Chapters 5, 6, and 7) and align with each research objective. This chapter begins with a review of the qualitative data convention and an overview of the participant characteristics. Next, I highlight findings from the thematic analysis of the data.

A total of three main themes and nine corresponding sub-themes emerged throughout the study. Therefore, this chapter will focus on the overarching theme and the first central theme of 'being well at work' and the corresponding sub-themes reflecting the voices of participants from across the data collection. In the context of relevant discourse, three separate chapters (Chapters 5, 6, and 7) describe each central theme and its corresponding subthemes.

5.2 Qualitative Data Conventions

The findings in Chapters 5, 6 and 7 followed several conventions to ensure a consistent and clear presentation of the data. First, verbatim quotes maintain the integrity of the experience and voice of each participant (Polit & Beck, 2016). Second, indentation and italic typeface clearly distinguish between the narrative and verbatim quotes.

I did not make grammatical or knowledge corrections to the participants' narrative. For example, participants primarily used binary language (i.e., women/men, male/female), which I kept respecting their stories. I also interchange between perimenopause and menopausal transition to align with the recent academic literature in this field. During the data collection stage of this research, I met participants at their comfort and awareness levels when using terms

related to this phase of life. There was a range of knowledge related to perimenopause, with many participants unaware of this life transition.

In this research, it was not essential to attribute a quote to specific characteristics of a participant. Instead, each participant received a number (i.e., P1, P2) to help report findings and demonstrate their voices across the research. I wanted to ensure that the findings are inclusive of all participant voices.

5.3 Participant Characteristics

I aimed to recruit participants who work in five of the six regions of Canada (StatsCan, 2016), across the various sectors of the physiotherapy profession between 35 and 60 years, who are living the transition from the reproductive years through menopause and beyond. While recruitment was complicated by the COVID-19 global pandemic, as physiotherapists were front-line health workers managing additional work, I recruited 35 participants within the first five days of promotion. Unfortunately, six participants declined to proceed with the interview as their work commitments intensified when public health guidelines changed from June to September 2021. These changes impacted their availability to participate in the research. However, they voiced commitment to the research question and requested findings and publications that emerged from the research.

In short, 29 interviews with physiotherapists living the transition from menstruation through menopause. Of the 29 participants interviewed for this research, one participant did not approve quotes for use in the dissertation or publications. Therefore, the interview was analyzed and included in the findings. However, careful documentation ensured that the dissertation, reports, and future publications did not include direct quotes from this participant.

The participants represent a segment of the profession. Each participant talked about their career trajectory across geographic locations and specialties. I did not document this trajectory, and the demographic data reflects characteristics from the last five years. Many participants transitioned between the public and private sectors. As they progressed in their physiotherapy career, they specialized in work areas, including pelvic health, head and neck, pediatrics, and stroke rehabilitation.

As I describe the participants in the 'sample,' I include their geographic location and some components of their intersectional identities. I am purposefully vague in sharing demographic data about the sample of participants as there is a potential risk for participant identification.

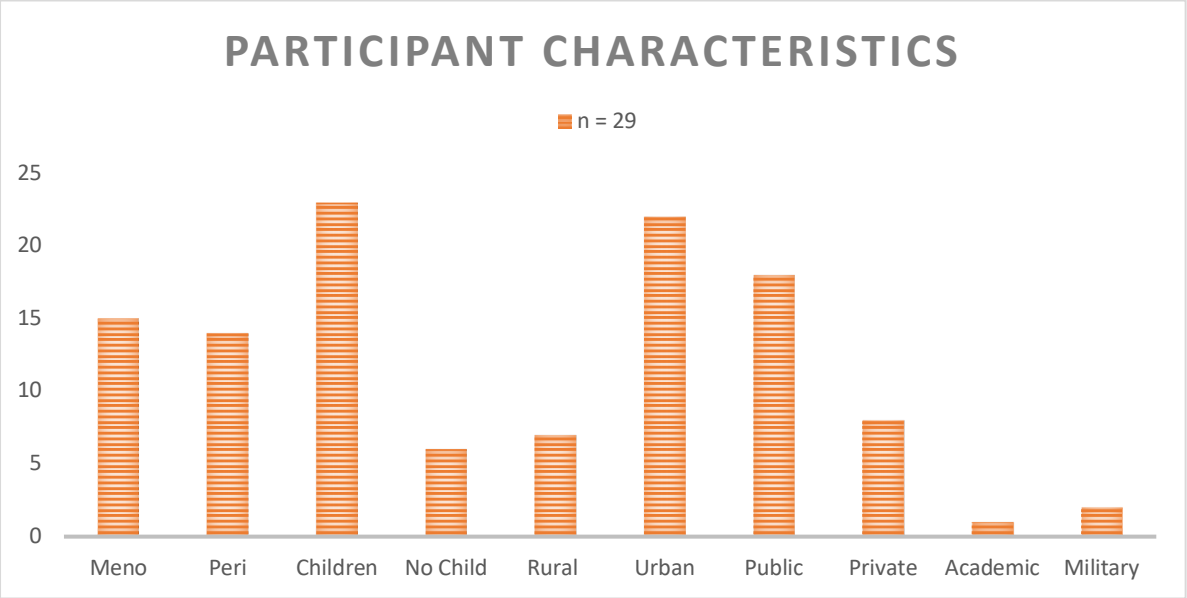
The following is a breakdown of the participants interviewed and where they worked during the interview (between April and July 2021). All participants identified as cisgender women. With the emergence of multiple descriptions of gender, future studies could extend the analysis to include non-binary, trans, and two-spirit perspectives in research on the menopausal transition in the workplace.

Participants' ages ranged from 39 to 65 years, with the majority (n=18) between 50-55 years. Fifteen participants identified as perimenopausal, and fourteen identified as menopausal or postmenopausal. There were 18 participants in a long-term relationship and eleven widowed, separated/divorced/single. Twenty-three participants had children, and six did not have children.

Participants interviewed had worked as a physiotherapist for 5 to 30 years. In addition, 22 participants lived and worked in urban settings, with seven in rural settings, based on Statistics Canada’s definitions of rural and urban. Finally, the participants identified their current work location based on Statistic Canada's six regions of Canada, with 13 in Atlantic Canada, 3 in

Ontario, 4 in the Prairies and 8 in British Columbia. See Table 1 for a summary of participant characteristics.

Table 1: Summary of Participant Characteristics



Participants were recruited based on their work as registered physiotherapists in Canada. The physiotherapy profession has a diversity of work environments, including academia, military, public and private settings. Therefore, the demographic profile does not report individual characteristics to maintain participant confidentiality.

5.4 Thematic Analysis of Qualitative Data

The six phases of Braun and Clarke's (2006; 2021) reflexive thematic analysis identified patterns across the data to understand the experience of perimenopause in the workplace.

Data familiarization and writing familiarization notes (Phase 1): This process was slow, with data from 29 interviews and 32 hours of transcripts (over 275,000 words). I needed to take breaks to allow time to process the data.

Systematic data coding (Phase 2): I used deductive codes to capture themes corresponding with the interview questions, existing literature, and concepts, while inductive codes explored

issues emerging from the transcripts. I tried to balance deductive and inductive coding while recognizing my role as the researcher in co-creating themes (Braun & Clarke, 2013). I created a list of themes and sub-themes as part of a coding manual. My academic supervisor reviewed the coding manual with two transcripts and provided feedback on the themes and sub-themes. A revised coding manual was developed to code the respective transcripts.

Generating initial themes from coded and collated data (Phase 3): The researcher and a second independent researcher trained in qualitative analysis coded the same transcripts to establish inter-rater reliability. The aim was to determine at least a 70% agreement, as described by Miles and Huberman (1994). In addition, I cross-referenced our two perspectives to reflect on areas of differences and agreement. As a result, discussion occurred over differences in the codes, and a revised manual coded the remaining transcripts. This process helped to strengthen the credibility of the results (Baxter & Eyles, 1997).

The agreed-upon thematic codes were uploaded to NVivo version 12 and applied to the transcripts. Once the initial coding was complete, I looked for larger patterns across the dataset and grouped the codes into themes (Braun & Clarke, 2006). Given that the experience of menopause in the workplace is an under-researched area, particularly from a qualitative perspective, the entire dataset guided the development of themes (Braun & Clarke, 2006).

Many sentences would have multiple codes depending on how I read the interview. I did not change the codes at this point but noted in my journal the duplication of codes and opportunities to combine some codes into new themes. During the coding process, I noticed patterns in the data, so I also developed rough diagrams of ideas that could create a thematic map later. The back-and-forth process helped me see the emerging patterns and map out the quotes that support the themes. I did experiment with visual thematic maps at this point in the process.

They were helpful tools for seeing the connections and relationships between different ideas and patterns.

Developing and reviewing codes (Phase 4): I started to write some ideas as part of the analysis (Braun & Clarke, 2012), which helped me to adjust the themes while noticing some of the gaps in my analysis. Throughout the process, I continued to work with the research objectives, which helped identify key themes according to their relevance and the predominance of the same theme across participants (Braun & Clarke, 2014). This iterative process of continually identifying themes and making linkages led to saturation, whereby the themes described the data (Guest, Namey & Chen, 2020).

Redefining, defining, and naming themes (Phase 5): I worked with the themes through a mapping process. I used post-it notes as part of this process as I needed to be more comfortable with the NVivo technology to develop thematic maps. Post-it notes on my office wall helped me review, reflect, and take a step away to allow ideas to settle and find connections. I continuously refined my ideas through the required time in and away from the data. It was helpful to present the initial ideas to my Ph.D. committee as this process clarified how the themes and sub-themes connected to the research question and objectives. After further discussions with my Ph.D. supervisor and colleagues, the development of themes and sub-themes with participant quotes connected the data and the theme.

Writing the dissertation (Phase 6): Even once the themes and sub-themes were documented, it was only through writing the dissertation that I could refine the ideas. This part of the process required the iterative element of revisiting the earlier phases to ensure that the findings represented the data and met the research objectives. At this part of the analysis, I also returned to the literature to connect with the data. The existing literature helped me review my

interpretation of the data and expand on the participants' experiences. I also returned to the original transcripts to ensure that my interpretation of their words was credible.

5.5 Findings

This research aims to broadly increase the understanding of the gendered dimensions of health and wellbeing in relation to the perimenopausal experience within the work environment, using a case study of Canadian physiotherapists. The overarching theme reflected how place-based experiences in the work environment impact perimenopausal physiotherapists. A total of three main themes and nine corresponding sub-themes emerged through the research (see Table 2). The main themes reflected how physiotherapists describe being well at work, embody the experience of perimenopause, and navigate supports within the work environment. In keeping with feminist geography, these themes and sub-themes were developed by understanding power and exploring the intersections of identity, knowledge, and agency as they relate to health and wellbeing (Tschakert, Coomes & Potvin, 2007). I will present each theme and its corresponding subthemes in the context of relevant discourse in three chapters (Chapters 5, 6, and 7). This chapter will focus on the first theme of 'being well at work' and the corresponding sub-themes reflecting the voices of participants from across the data collection.

TABLE 2: Themes and Sub-Themes

Place-Based Experiences in the Work Environment impacting Perimenopausal Physiotherapists		
Objective	**Theme**	**Sub-themes**
To examine the relationships between aging, gender, health, and wellbeing in the workplace	Being Well at Work	1.1 Finding Balance 1.2 Transformative Experience 1.3 Redefining their Purpose
To explore the experiences of perimenopause for physiotherapists in the Canadian work environment	The Embodied Experience	2.1 Unpredictable Body 2.2 Exploring the Invisible 2.3 Normalizing the Transition
To document the perceptions of existing structural support(s) in the workplace shaping physiotherapist's experiences with the menopausal transition	Navigating Supports	3.1 Reflective Practice 3.2 Community of Support 3.3 Institutional Structures

5.6 Overarching Theme: Being well at work

Physiotherapists are committed to meeting their patients' diverse and complex needs in various clinical settings and educational environments. All participants spoke about their passion for the profession and supporting their patients to meet their health goals. At the same time, they recognized the job's demands and talked about the physical, emotional, mental, and spiritual energy required to be effective in their role. Participants overwhelmingly shared the value of being healthy to perform their job with patients and collaborate across health teams.

> *I'm a health giver, so I feel that I cannot be effective if I'm not healthy. And that's one of the things that's very important to me. (P05)*

Participants took pride in their work and ability to support a patient's journey to wellness. This passion to be a professional and provide evidence-informed health care was pivotal when participants spoke about being well at work.

> *Feeling well at work means I'm able to accomplish the demands of my work, the responsibilities, and tasks of my work completely, are comprehensively and to a standard that is important to me. (P22)*

As they described their career as physiotherapists, the narratives showed a relationship between being a productive team member and being well at work. Initially, participants identified signs (i.e., energy levels and loss of muscle mass) associated with aging as contributing factors impacting their perception of productivity and wellbeing in the workplace. As we further explored what it means to require "a little more effort," the narrative deepened into the experience of aging as a woman and going through the menopausal transition.

> *It's all part of me being well and being able to show up and be present with my patients. And certainly, as I age, it takes a little more effort. (P06)*

Participants expressed a sense of responsibility for their body's unpredictability, guilt for their inability to manage symptoms, and difficulty articulating the mental and emotional health aspects of being well at work. Participants believed that providing high-quality care to their patients required attention to their health and wellbeing, particularly as they age and transition to menopause.

> *To be well at work is to feel like I can, I've done what I can do reasonably for the people I'm seeing... to be a contributor to the amazing people I work with just whether that's, you know, knowledge base, or just support, like emotional support (P09)*

The subthemes contributing to this theme are: 1) finding balance, 2) transformative experience, and 3) redefining their value. Each subtheme highlights critical aspects of the experience of perimenopause at work, which can help inform healthcare professionals' practice, enhance health education curricula, and influence policymakers' frameworks.

5.7 Subtheme 1: Finding Balance

Participants noted that a career as a health professional requires skills and competencies in communication, negotiation, time management, collaboration, advocacy, and clinical expertise. They talked about how physiotherapists are attentive to their patient's physical and emotional safety while assessing and diagnosing patients to develop, implement and evaluate an intervention plan. The complexity of the clinical role of a physiotherapist requires cognitive attention, physical strength, stamina, and communication skills to engage with patients and healthcare teams. While the training and professional development of physiotherapists support their ongoing growth and continuous quality improvement of their practice, participants shared their experiences with the strains and stresses within the health system impacting their ability to be well at work and to find balance within and outside the workplace. These demands were present before the pandemic, with increasing rates of chronic and complex patients, growing caseloads, and a shortage of healthcare workers. Participants acknowledged that the clinical setting (both public and private) have fast-paced schedules with unwell patients waiting for treatment and care. Participants spoke about high expectations for physiotherapists to perform consistently at an optimum level.

> *I think this is where I really struggle… It's a balance, having a balance of my... I love my job. I have the best job; I think in the physio world. But I struggle with the balance of taking my breaks, taking my lunch, working within the hours that I'm*

supposed to work. So, I think being well in work is liking what you do, doing it well and looking after yourself while you do it. (P14)

Participants were motivated by their desire to deliver care for their patients and recognized that their health was essential in this equation. They believed their healthy habits would benefit their patients. As they attain and maintain their wellness, they believe this strategy reflects their ability to support their patient's treatment plans.

When I think of health, it's everything that surrounds health. So, eating well, sleeping well, being active, also mental health. Yeah, so it's the whole thing and because I'm a health giver, so I feel that I cannot be effective if I'm not healthy. And that's one of the things that's very important to me. (P05)

Participants reported the importance of rest, being cognitively alert and physically engaging in their work as critical aspects to their success. Physical and mental health impacts engagement with their work and the health and wellbeing of their patients. There is '*no pause button at work'* (P09), reflecting that they must be ready to engage at total capacity all the time. Yet, referencing their perimenopausal symptoms of chronically interrupted sleep, they do not feel fully present and engaged in their work.

It means that I'm rested, you know, and I can be there, really present for my client. And I'm able to think about what's going on. I find that if I go to work and I'm too tired, and I can't think it's not good, you know, like in physiotherapy, you need to be able to understand what's going on and, and be on your game all the time. So if I'm too tired, I feel in this way it really affects my work. (P19)

Participants reflected on the complexity of working as a physiotherapist and being well with the physical and cognitive demands of the role. Team support and camaraderie were a

thread throughout many narratives on how to manage difficult situations, talk about perimenopause, and find joy in the job while engaging with patients and team members.

> *To be well at work means physically, first of all, to be able to do this physical job that we do have. So, to be able to do the physical work without pain. Also, mentally to be I guess, sharp, you know, to be able to do your decisions, make your decision, your clinical, your clinical thinking, critical thinking. And also, well means to be able to enjoy oneself, you know, at work, like for me, that's, that's a big deal. Like, I need to be able to, to laugh and enjoy myself and have meaningful connections. (P28)*

Through the interviews, participants found it challenging to focus solely on their work lives. For example, one participant spoke about how *"relationships transcend"* environments making it difficult to differentiate the menopause experience(s) at home versus work settings.

> *When I started work, the kind of adage was, you know, leave your work at the door, and leave your home at the door. When you come into work, you're to work. And I think that was the adage of the early 90s, probably the 80s as well. And we know that relationships transcend, right. And everything transcends that it's not, there's not work and home, it's blended. But certainly, back in the day that was the feeling that basically when you come to work, you park everything that's going on in your life and you work. (P20)*

Finding balance by separating personal lives from their daily work expectations was challenging. Some participants enforced balance by intentionally creating a divide between work and home. They left the work stress in the clinical setting to physically leave the space to relax and spend time with family and friends. As participants aged and managed their menopausal

symptoms, these parameters were a strategy to cope with the competing demands for their health and wellbeing.

> *I have also learned over the years for my mental wellbeing that whatever happens at work, needs to stay at work, like I cannot take ownership for what's happening to my patients. And to me, that's what allows me to go on with what I do. (P05)*

The data presented tension for participants who chose healthy lifestyles, yet their physical and mental health symptoms throughout perimenopause did not reflect these choices. For some participants, these symptoms were unfamiliar and confusing as they began to experience weight gain, while others struggled with new mental health conditions. Participants described their mental health by engaging in a medical model and using psychiatric labels (i.e., depression and anxiety) to make sense of their changes and distress. It was not always clear if participants had received a clinical diagnosis or were self-diagnosing to legitimize their stress and fears. Participants described their anxiety or depression as an "illness" brought on by their experience through perimenopause.

> *I felt like a hormonal shift. And I said, oh, wow, this is depression, like fully, fully, fully steeped into depression, because I really lost just all, all desire to engage in life. (P04)*

The perimenopausal changes impact physical, cognitive, and mental health, compounded by the lack of knowledge about this phase of life. For example, participants were unaware of the timing of the menopausal transition and that it could take over a decade and start in their early 40s (and earlier). This lack of awareness meant that participants were not cognizant of the potential impact perimenopause could have on their health and wellbeing. In addition,

participants were not attentive to small signals of change in their physical and mental health attributed to hormonal changes.

> *It's just a gradual entry that doesn't bang, symptoms. They kind of just gradually come on. You know, and I think I just probably look back and think oh, that's probably why I wasn't as calm as I'm usually or able to handle stressful situations. (P11)*

Participants recognized that they needed to modify their approaches to find balance as they age. They focused on their needs and finding a voice to express these parameters to be healthy and well at home and work.

> *And what I found over the years is that I become unbalanced. And I give more to other people than I give to myself. So, it's trying to find that happy medium, which is an ebb and flow. I find at least for me, yeah. And, and I find right now I'm, because of where my kids are, in the stage of life I'm at, I'm able to give a little more to me, which I'm really liking. (P09)*

Participants described the challenge of being professional at work in a busy and stressful environment while experiencing symptoms like hot flashes, exhaustion, mood swings, and memory loss. By the end of a workday, participants recognized that they had hidden their symptoms from their colleagues and patients, which meant they were exhausted and unable to "*bring their best self*" (P02) to their families.

> *So, it's your family that suffers because you have to hold it together as much as you can at work. And then, you have to let it loose sometimes. So yeah, so challenging, for sure. Challenging. (P11)*

Throughout their careers, participants prioritized self-care, recreational activities, and overall wellbeing by establishing and maintaining health through work-life integration. Participants leaned on their social supports and normalized asking for help in relation to child-rearing and caregiving roles. Participants set boundaries between work, home, and personal wellbeing. However, as they aged in the workforce, there were fewer peers and limited opportunities to discuss perimenopause in the workplace. The lack of discussion in the workplace about perimenopause contributed to the knowledge gap and silence about the transition. Peer support and space to actively seek collegiality to reduce isolation were limited and more challenging to find in the work environment.

5.8 Subtheme 2: Transformative Experience

All participants identified varying degrees of physical, cognitive, and psychological changes, including night sweats, hot flashes, sleep disturbances, exhaustion, impatience, forgetfulness, brain fog, depression, anxiety, and irregular menstrual cycle. However, some participants were unclear if these symptoms were from aging or the onset of menopause. In addition, the transition to menopause occurs during other significant life events, including increased caregiving roles (i.e., raising teenagers and supporting aging parents). These life events make it difficult for some participants to speak only about their experience of perimenopause.

> *I do wonder. It is hard to pull out what is the menopausal experience versus regular stress, aging versus COVID. I have this assumption that if your tank was full, you might respond different. And your tank is depleted for various reasons. And one of those reasons may be menopause, even if you don't think about it that much. (P14)*

The reason for these changes (menopause or aging) was not as important as its impact on their lives. They were concerned that the changes would get worse, and the uncertainty of the changes was difficult for them to manage. Some participants spoke about denying this phase of life, which meant they did not seek out information, talk to friends, or explore options with their physician. "*I didn't really read a lot about it because I think there was a denial piece in my head."* (P10) They wanted to avoid the experience of menopause and *"assumed it wouldn't happen to me."* (P14)

Many participants expressed their lack of awareness about perimenopause, and their limited knowledge impacts their personal and professional lives.

> *It's like you don't know what to expect, and what will be your own experience. It's something I'm gonna say scary. But it's just like, when you're pregnant with your first child, you don't know how giving birth is going to be. And people are telling you all these horror stories, you don't know what to expect. But I guess everybody's experience is different. And basically, I was a little bit worried, but mostly curious about what my own personal experience will be like. (P05)*

Other participants relied on medical tests to confirm their menopausal status and rejoiced at the end of their menstrual cycle:

> *When I finally had the blood work that said, 'Yep, definitely no chance of any eggs being released'. It was actually freeing. I was like, finally, I don't have to worry about that worry. That had been a worry for however many decades. (P26)*

Balancing out the expressions of fear was a sense of hope for the future. Participants discussed the opportunities before them as they embraced their future in menopause.

Means I am getting older. And that I don't like, that normal aging process is, it's just another stage in life, and I enjoy the stage, but it means that 20-25 more years is it.. for a healthy adult, so and that does not thrill me at all. But at the same time, when I was 20, what I have ever imagined everything I would have done between 20 and 59. There's a lot that could happen in 20 or 25 years. That's could be awesome. So for me, it's the passage of time, that is alarming, not the symptoms of the passage of time. It's just that marks another spot on the timeline. (P26)

Part of this transformative experience is a stronger confidence to engage in work as an experienced physiotherapist contributing to the growth of a team and the health and wellbeing of their patients.

I'm more confident with myself and that I'm more willing to just listen to others. But if I have something to say to say it and yeah, I think I feel respect from my peers. (P15)

Through this confidence is a renewed sense of self as participants find their voice.

The other piece was being comfortable with who I am. Embracing all the knowledge that I do have. Because I have that life experience, as well as, as well as you know, the knowledge but the life experiences and learning how to value that. That's, that's sort of where I'm at right now. (P06)

The data showed ongoing negotiation about the role menopause plays on the individual physiotherapist and their relationship with their patients, colleagues, and the work environment.

It's like achieving a new integration. So, before the work, the work part could be imbalanced. And now it has to be reined in. Like, I can't do it. So, I have to work fewer hours, I have to work more intelligently. I have to lower my standards. I am a

perfectionist by nature, and it's why I've gotten to where I am, but I have to lower my standards, not correct as much when it doesn't really matter, I have to learn when it does matter. And when it doesn't. And instead of being a perfectionist in everything. So that's what I've had to adjust to this new reality. (P22)

Participants described the transformative experience as a journey beginning with limited knowledge about perimenopause and denial that this was their time to be in this transition. Through reflection and over time, they emerged to a space where they sought knowledge about perimenopause, explored the meaning of this change and accepted this new phase of their life. Through this engagement with information, participants became more confident in their personal and professional lives as they grappled with fears of aging, the meaning of menopause and their future.

5.9 Subtheme 3: Redefining their Purpose

While there are many motivating factors for why individuals choose to become health professionals, participants in this research spoke about a calling to help others and engage in meaningful work contributing to improving health outcomes.

Health and wellbeing for me, has evolved and I think for me, it's always going to be about doing something that I feel has purpose, so I don't feel good when I'm not there. Right. So that purposeful work. (P20)

As participants described their experience with perimenopause, they framed their engagement within the workplace across a continuum. The continuum ranged from a perception of invisibility to a space of feeling valuable. By self-monitoring their engagement in the workplace, participants framed their roles, purpose, and future in the setting.

I keep looking at it as experienced and wisdom and all of that that goes with it. I've always said, you know, if I start to look like I'm getting into rut, and I can't change with what's going on, then I shouldn't be here anymore. I don't want to be, like guess, I guess I saw some people getting ready for retirement or getting older that you're like, oh, you know what we need to... when you leave, then we can change this. And I don't want to be viewed that way. I want to kind of always be one that's not in the way of progress that I'm helping progress. (P09)

Transmission of knowledge across generations and reflecting on one's life course leads to opportunities to mentor and support the development and wellbeing of successive generations. As participants identified ways to reflect on and use their life experiences, they recognized that this creates space for wisdom. Participants acknowledged that "*aging also means a lot a lot of wisdom*" (p12) and physiotherapists should "*embrace your wisdom*" (P06) while celebrating "*how much an older woman has to share*" (P04). Participants described the value of mentors in their transition and how this translated to supporting patients, colleagues, and friends as a means of gaining control and demonstrating their value and wisdom.

I received those women in the clinic, right who have menopause issue and, and I want to be able to help them and I want to be able to inspire them and be a model, but I have to be able to do this, I need to have dealt with it myself. And I will say that I'm pretty much in the process of doing this. I haven't found all my way yet through this, this new phase of my life. (P19)

Participants described a duty and obligation to give back to society by supporting individuals going through menopause and being role models for this journey.

I can recognize symptoms that I'm familiar with, right? So if I see someone, you know, going through, tend to be a little more irritable, or then, I can recognize that because I went through it. So I'm familiar with those symptoms. And then, I can, if I can just have a bit of a conversation and just share my story, right. I'm not going to say, it's this is because of what but you know, I can least share some experiences. And then at least people know they're not alone. If it's when we share our story, I find it's helpful. (P11)

As part of contributing to the physiotherapy community, participants were eager for information to support their patients through perimenopause.

I just can't wait to learn more and more about it and, and every personal thing that I go through, I look at it as a wonderful learning experience for my career. (P04)

Participants shared their concerns about their cognitive changes (including memory loss and trouble with word finding) as part of perimenopause. They worried that these changes might hinder their ability to engage in problem-solving, reasoning, and critical thinking as a physiotherapist. In contrast, they recognized that the accumulation of life experiences and the ability to integrate experiences across time in a reflective manner are critical. In addition, they acknowledged wisdom as more than knowledge but the application across the work environment and the clinical setting.

But aging also means a lot a lot of wisdom. I find new grads are totally fixated on this course or that course. And I've had other physio mentor with me and they would always ask me what course did you learn that in? I tell them stop asking me because it's not A course. It's an accumulation of all my education and work for me. (P12)

Participants highlighted how language silenced them or made them feel invisible. The inconsistency in language around the menopause transition created confusion. Participants reframed and reclaimed language to develop legitimacy to their experience. In addition, participants wanted to be part of the changing the discussion about menopause in the workplace.

> "*I'm really wanting to change things. I'm a bit upset with the way menopause is being seen and dealt with in our world". (P19)*

For some participants, there was a conscious effort to reclaim language to break the stigma and taboo around menopause by renaming hot flashes to "*power surge*" (P16), and "*red zone*" (P02), and their emotions to "*dirt devil*" (P15) or "*funnel cloud*" (P15). In addition, some participants decided to claim and reclaim language as a strategy to empower themselves and find comfort in the changes taking place in their lives.

> *I was just like having a power. I called it power surge. I didn't do the hot flash I just I thought power surge sounded more powerful. (P16)*

For many participants, menopause has been medicalized and pathologized. Through the interviews, participants recognized that the transition requires support from others with similar experiences rather than only professional and medical services. The complexity of the transition beyond the physical symptoms to the feeling of isolation and lack of support can leave participants assuming something is wrong with them for their perceived failure to cope.

> *I feel that I'm able to achieve with my clients, what they have come to, to why they have come with their question. So, then I'm able to help them with that question. And then I feel satisfied with that I've been able to help them. So, I don't feel frustrated with it. Not with myself and not with the process. (P17)*

Participants struggled with the gaps in their training to become a physiotherapist as it focused on the biomedical, mechanical, and physical aspects of health, wellbeing, and the body. In addition, they referenced limited knowledge and training in mental health and emotional wellbeing. As they age in their profession, they recognize the importance of integrating a holistic approach to working with their patients that engages a better awareness of wellbeing.

> *It seems like with their [OT] knowledge of cognition, with their approach, about you know, activities of daily living returning to what's meaningful to someone, it seems like they're more trained around that they have more psychology more psychiatry, background. And, and the physio comes in, they have to do stairs, and they have to walk and we have, we seem to be more physical. And with that, sometimes I will approach someone, for example. And very quickly, you realize I'm not going to be able to do what I need to do. (P28)*

Feeling and being valued in the workplace was important to most participants as they work in team environments where they feel it is important to "*celebrate your accomplishments" (P23).*

> *Wellness at work, really, I think really means being supported. And so, if you don't have that feeling of support at work, then you don't have that potential to step into your own mental and physical and emotional and social wellbeing. (P04)*

As part of being well at work, participants recognized the importance of *"embracing all the knowledge that I do have"* (P06), while intentionally creating supportive teams with role models and mentors that ensure the voices and experiences of menopausal physiotherapists are celebrated and valued across the health care team, profession, and workplace.

5.10 Chapter Summary

In this chapter, I presented the theme and sub-themes of being well at work throughout the menopausal transition. Although this research sought to understand the experience of perimenopause in the work environment, the data expanded to explore and consider aging in the workplace. The larger aging narrative created a critical backdrop to locate the stories of the transition to menopause. Many participants spoke about evolving awareness and understanding of health and wellbeing influenced and impacted by age and gender. As health professionals, participants were empowered through their role as physiotherapists and supporting their patients to improve their health outcomes.

Participants prioritized their overall wellbeing throughout their careers by establishing and maintaining work-life integration. Participants leaned on their social supports and normalized asking for help in relation to child-rearing and caregiving roles. However, as they aged, peer support and space to actively seek collegiality to reduce isolation were limited and not to find in the work environment. As part of aging, participants explored their transformative experience while creating space to contribute as valuable members of the health care teams.

Chapter Six: The Embodied Experience

"Something about my deep being is changing" (P10)

6.1 Chapter Outline

In this chapter, I present findings that examine the second objective of this research: to explore the experience(s) of perimenopause for physiotherapists in the Canadian work environment. The theme, embodied experience, reflects beyond the physical aspects of menopause to explore the invisible dimensions of the transition and their impact on physiotherapists in the workforce. The sub-themes contributing to the overarching theme are 1) unpredictability of the body, 2) exploring the invisible, and 3) normalizing the transition. I will present each of the sub-themes in more detail below.

6.2 Overarching Theme: The Embodied Experience

Our bodies are core to our experiences in the environments in which we live, work and play. Our bodies keep a record of our lived experiences. This record reflects the health and wellbeing of our bodies. Our bodies bear witness to the conditions of these encounters. While this research focused on the work environment, the divide between places and spaces are difficult to delineate. The experiences shared by participants reflect the significance and the relationship between their bodies and places they identify as crucial, including home, recreation, and work.

When asked what was most important to them with respect to the transition to menopause, all participants began their stories through experiences with their body. Specifically, how they felt about and experienced their bodies as they aged. Participants spoke about their relationship with place and space over time and as they experienced aging through their body and through the

transition to menopause. The changes in their body impacted how they felt, thought, and responded in life and their workplace.

> *I feel like menopause is a real like taboo subject and it's filled with shame, you know, you're starting to gain weight, and the society tells us that we should be beautiful, and we should have a flat tummy, the whole length of our life. And so it's hard for women to gain weight and still love their body. (P19)*

The intertwined narratives started with a focus on the bio-medical position of the menopausal body as a site of disease and distress requiring medical intervention. The narratives explored the embodiment experience by weaving through social and cultural perspectives in which reflection, new priorities, new identity, and a recognition of a renewed role in society and work emerged. *It was a real sense of something about my deep being is changing. (P10)*

6.3 Subtheme 1: The Unpredictable Body

While each participant shared their unique perspectives, there were familiar narratives about the unpredictability of the transition that emerged throughout the research. This unpredictability in the body and mind resulted in a renewed sense of self. People who menstruate have learned to notice, wait for, track, monitor, and manage reproductive signs and symptoms for the entirety of their adolescent and adult lives. With the arrival of new or adjusted signs and symptoms, participants had responses ranging from not being startled to being a complete surprise.

> *So, I never had any problems with my own menstrual cycle, as I was going through my regular life, I was not pms'y if you want to use that word. I had, I just did fine. I was a pretty even keel, normal person. And then something happened. And I didn't quite grasp what's going on. (P02)*

While some participants were positive and ready for the changes, most were surprised and unprepared for the impact that these changes would have on their bodies and their lives, including their work. Uncertainty and unpredictably made it challenging to plan and prepare for what was about to happen.

> *I was always regular and then I started having my periods every three weeks for eight days. It wasn't fun. I was having mood swings. I was...hot flashes at night, like really bad. (P13)*

The invisible markers of perimenopause, including hot flashes, night sweats and flushing, align with visible, age-related changes in the body, such as grey hair, wrinkles, and sagging skin. In addition, participants raised concern that these changes may be perceived to impact their professional roles and competency.

> *...lose that balance, because you're older, you're more experienced, but then you start to actually look older, too. So, you have, I felt that sometimes that was appearing to be like a weakness of mine, for my part, that people were viewing me that way. And maybe that's not even true. But that's the way I felt. (P23)*

Participants noted that the aging experience from a gendered lens created a different experience and dialogue for women and men.

> *It seems like it's easier somehow for guys to, I don't know what would have to ask a guy but in my head appears to be that it might be easier for guys the aging process and except when they get like at a point where it really affects them where it affects their you know, erectile function and all that stuff. Otherwise, I think guys are it seems like they're aging easier. (P19)*

Participants felt that society viewed women as having a *"shelf life"* aligned with their physical appearance and closely connected to retirement. They experienced answering and defending their retirement decision (or lack thereof) within the public (and work) domain.

> *But the one annoying factor I found with ageism was people constantly asking me because I'm grey "When are you retiring at?" I kind of look at them going...my colleagues retired at 74. Another colleague still practicing at 68. So, I like... that one does annoy me. Because would I ask a grey man that …Or man who's bald? I know that sounds mean. But I found that, you know, I was 50 when people started asking me "so when are you retiring? How long can I see you?" Or "will you be here when I get vertigo again?" (P21)*

Some participants struggled with how the health care team engages with patients about physical discomfort (i.e., pain) but there is a gap in discussing menopause. Participants questioned the relationship between this silence and an aging and gendered body.

> *I mean, we can talk about pain, but not, but not about menopause. Because I don't know why. Because it's about dry woman or so, or women who are shriveling up, or aging, or I honestly, you know, those are all very good questions. (P17)*

The profession of physiotherapy requires physical, mental, and cognitive stamina to assess and treat patients in changing clinical, health care and education environments. Some participants struggled to maintain their clinical practice as they aged and felt the symptoms of perimenopause. To maintain their clinical practice, some participants spoke

about modifying treatment plans, changing their population base, or switching their scope of practice.

> *I used to work with children, that I'm now really choosing which child I will work with, because I can't be on the floor so easily. And I can't crawl around much because of my knee and my new knee. So, I have to adapt. Whereas before, I was always able to use my body in the way just the way I wanted to and needed to. And now there's limitations to that. So, there will be patients that I say "I will not treat you, I can treat you". So, I refuse people. I refuse. I say, I can't do it. So, so there is that definitely that change. I have to be more careful with what I do with my body. (P17)*

For some participants, perimenopause was experienced as a matter of decline and decreased bodily and cognitive functioning. Participants referenced perimenopause as an intense time in which they had no control, and they were not sure what to do to address symptoms. Participants spoke about the intensity of the transition and that it was "*quite traumatic" (P16)* with sudden changes in which they felt they might be "*a little cuckoo*" *(P02).*

> *It's devastating. That's all I can say about it. It's a devastating part of life that where you don't know what your body is doing to you. Your body is doing things and you have no control and you don't know what to do. (P17)*

Participants spoke about a misunderstanding of the body reflected in "*out-of-body*" experiences representing a disconnect between the unity of self and body. Some participants referenced being detached both from their body and the experience of perimenopause during times of intense symptoms.

An out of body experience where you're looking down, you know, in the in that you're watching your own body do this. (P02)

In contrast, some participants shared their enhanced ability to engage with patients as they had a shared lived experience. The relationship with the body is not static and alters daily, developing through experiences, changes in appearance and abilities, and reactions from other people. While other participants believed that they gained strength through the transition which helped them to engage with their patients as they could relate to their experiences, provide training, and offer a space for support.

I'm very grateful. For that. And I think that anything, like I say anything that I experience is great, because then I can speak a little bit more openly with patients or question them and say, "Hey, is it possible that it's this…have you? Did you speak with your doctor about that… that's a possibility." (P04)

Initially, the individual experience of the menopausal transition presents through the relationship with the human body focusing on the observable truths about aging and menopause. The body is an integral part of self-identity. How we respond to our bodies and how others respond is critical to our self-confidence, self-worth, and self-esteem. The body is constantly engaged in the world, and these body changes impact how the body experiences the world. This relationship with the body is personally and professionally significant to a physiotherapist. Through engagement with physical bodies, physiotherapists provide health care to improve the mobility and wellbeing of patients.

6.4 Subtheme 2: Exploring the Invisible

Discussions about menopause are often situated in the physical experience with a focus on the decline in hormones, hot flashes, sweating and the associated treatment

modalities. However, through deeper engagement, participants began to describe less visible experiences, notably the impact on their mental health, cognitive functioning, and emotional wellbeing.

> *I felt like, "Okay, I'm getting into a rhythm", I'm doing some, you know, exercising and sleeping, starting to sleep a little bit better. And then I can't remember what it was, it was last...might have been late last summer, or maybe in the fall, anyway, doesn't matter. And I felt like a hormonal shift. And I said, oh, wow, this is depression, like fully, fully, fully steeped into depression, because I really lost just all, all desire to engage in life. (P02)*

Emotional changes were unpredictable and concerned many participants, and they reported not recognizing whom they have become, which demonstrated the accompanying angst with these changes.

> *And then suddenly you cry for like, what the hell like, I don't know why I'm crying, but I am. Or I think not. I don't know why I'm crying. But why is this making me cry? Normally, it wouldn't make me cry. (P18)*

Many participants were surprised by their emotional changes throughout the transition. They referenced feeling out of control and unable to manage their emotions during this time.

> *I also had some brain fog. I had some just mood swings, I used to call it my dirt devil. I could, it was like a little storm coming through me. And it would also not be very mad. And it wouldn't, there was nothing I was should be mad about. But I just felt like yelling at someone and, it's like, woah, I just feel like yelling or throwing something or, like, I just felt mad. And then I would say, "Oh, my the dirt devil is*

going through me", like, you know, that looks like a funnel cloud is going through me. And so, I just sort of let my Dirt Devil go through me. (P15)

An impact on emotional wellbeing is the self-described changes in cognitive functioning, including brain fog, inability to pay attention, memory loss, and word-finding difficulties.

I felt that growing sense of not being able to, um.... not being able to manage the workload from a mental capacity, I felt really mentally drained. And I don't know if I would call it like brain fog. I just felt like I had reached my capacity. And so whereas before, that wasn't a problem. (P04)

The unpredictability of the body throughout the menopausal transition impacted their relationship with patients and colleagues. In addition, participants reflected on how they manage and cope with stress throughout the menopausal transition, which in turn was challenging in work environments.

My tolerance band is narrower, that I don't have the ability to recover or be resilient around some things and put them in context. They kind of overwhelmed my head. I do think that's menopause. I do think that that's something around my age to be able to tolerate stress. (P20)

These emotions required energy to understand, manage and control particularly at work. Participants who spoke about extremes of emotions also talked about how they managed to *"keep up appearances"* within the work environment and found they were exhausted when home with their families.

It's not that big a deal. But for me, there is a certain amount of irritability. But I've once I guess in my life, if I hold up the mirror and I see my actions, and the impact

they have on other people, then I can monitor myself and make sure that I'm doing what I need to do to stay on an even keel. So that the people around me don't get the brunt of that and you know, 95% successful. (P26)

Participants felt that colleagues, managers, and family were supportive of the physical symptoms but less tolerant or understanding of the invisible symptoms, which many participants expressed as more challenging.

I just had a meltdown with my family and my husband and my kids. And I just said, "Look, you have no problem accepting hot flashes. But what about the sleepless nights, the depth of sleep deprivation, the brain fog, all the things that go with it, you need to be more patient with me." (P16)

Physiotherapists train to help patients actively engage in their environments with their body. Participants reflected on their comfort with physical ailments, disabilities, and illness. However, the transition to menopause is outside their training, and they are not always comfortable discussing it with patients. The silence about perimenopause is evident in conversations, treatment, research, and patient engagement. Participants noted physiotherapists reflected society's comfort (or lack thereof) with menopause.

There's so little known and so little attention and so little, embracing that. People talk all the time about their total knees and total hips and how the surgeries this and the surgeries that and we have special programs for them in the Rec Center. But we're not ever talking about menopause. (P17)

Some participants questioned the role gender plays in the lack of discussion about menopause in society and the workplace.

Fibromyalgia was considered a sort of a made up disease in your head kind of thing. I think menopause is a way to continue to keep women. The way it's managed the way its talked about, keeping women in their crazy box. It's kind of like, "Oh, well, you know, it's like, oh, you know, she's riding the red wave or whatever." (P20)

Participants expressed concerns about the training to be a physiotherapist in which they focus on how the body functions and pay less attention to understanding the mental health needs of their patients. This gap reflects how physiotherapists experience perimenopause in the workplace.

I find the mental burden is different when you deal with people every day and their problems, right. It's like at some point you become, it's a mental fatigue, it's a clinician fatigue. And so I don't...and on top of that the job is a little bit physical. (P18)

Participants also rated symptoms they could manage and prefer, particularly in their work. They were concerned about the emotional and cognitive functioning impacting their relationship with patients and coworkers.

I can deal with hot and sweaty if I'm not killing anybody, and I'm not yelling at people, and I'm not irritable (P02)

Through the narratives, the menopausal transition was shaped by physical, mental, cognitive, and emotional experiences recognizes that there is not one universal experience of menopause. Participants acknowledged that their bodies are sources of identity and meaning through an embodiment perspective that engages with the hidden narratives. Participants noted a growing appreciation for the fluidity of the menopausal experience(s)

as they embrace the lived experience, agency, and an expansion of the mind-body dichotomy. No one story provides one truth over another.

Participants varied in their experience of menopause and aging. Some equated the transition with a medical condition, others as part of the normal aging process and others expressed uncertainty about what it meant. These differing understandings are essential because they can mediate emotional and psychological responses. Participants in this research expressed a range of experiences from anxiety and depression to embracing the changes as a positive contribution to their lives. In addition, participants described the transition as a time for reflection to find their voice in their organization and profession.

6.5 Subtheme 3: Normalizing the Transition

Medicalizing menopause as a disease requiring treatment prepares women to expect the worst. Participants spoke about the uncertainty throughout the transition and attributed this uncertainty to the lack of clear definitions and language for this phase of life, tension about aging, lack of information and education, and the unpredictability of symptoms. Since social meanings and expectations commonly shape the actual experience, participants reported the need to disseminate a more realistic and balanced narrative that challenges the stigma around aging and recognizes perimenopause as a natural process with both positive and negative aspects.

Participants referenced societal expectations of aging, the meaning of beauty, and our relationship with our bodies. Many participants reported that they were "*shocked that what I went through, I didn't know anything about it, because nobody talks about it." (P17*) The taboo on menopause means that it is not discussed at home, among friends, at work or in public.

Participants spoke about the shame that underlies perimenopause which creates silence in society and adds to the stigma.

> *There is a perception there is a shelf life for women in the workplace. Menopause is associated with a decline in function. It is associated as negative. How has there been a framing of this cultural reflection of women in society? (P02)*

Participants recognized that it was time to begin the conversation and be brave in challenging the stigma and taboo related to menopause.

> *It's not talked about. And maybe we feel uncomfortable about it ourselves. And that's why we're not talking about it. But, you know, it's like with anything, I think we just need to start somewhere…..So it's about opening the conversation, I think. So it's a question of time. Is the time ripe for it that people are open to listening to and knowing about different stages of life? (P17)*

In addition to the taboo, many participants referenced their denial of aging and entering the menopausal transition. This denial kept the doors closed for conversations and preparation for the transition.

> *I don't want it to happen just yet. Not like, I'm not ready to age. I'm already having trouble accepting all this. So not accepting. It's just like, Oh, no, I'm already there. Like, so I just don't want to be there yet. (P18)*

As this research took place throughout a global pandemic, some participants reflected on the impact of public health measures on their experience of menopause. Participants reported a positive change emerging as conversations about stress, anxiety, and wellbeing become part of our dialogue and support in the workplace. Participants believe that these changes in the workforce will benefit people experiencing the menopausal transition.

That's a silver lining right in there. We know we've seen some right through this pandemic. Because it's, if you're in perimenopause, and you're maybe a little more vulnerable to the stress around you, your anxiety levels a little bit higher. So then the resources, it's much it's more common, and it's an easier discussion, to have right between colleagues and yourself and your manager to say, "Hey, you know, I just, you know", when as physios, we're used to saying, "I have sprained ankle, I can't work". But we're not used to saying, "I have some major anxiety. I can't work". So at least those conversations are a little bit or just a little more becoming more familiar in the workplace, which is good for everyone. (P11)

The intersectionality of identities emerged throughout the narratives as participants began to examine the relationship between gender, age, health, and wellbeing. Participants were inquisitive about how society explores aging through a gendered lens.

It is the part of aging, which is natural, right? And it happens, it is expected. Maybe for that reason, it doesn't get a lot of attention. Just the way things are meant to be. Some people think that way. Right? If it was another topic not related to women, I'm sure we would be talking and hearing a lot more about it. (P29)

Participants recognized that discussions, policies, and programs specific to aging in the workplace target seniors and bypass mid-life. Participants reported that this time of life has a significant amount of change requiring attention, discussion, and research.

We're just not talking about aging. We're talking about aging, for people who go into old age homes, that's about where it starts. The last stage of life, that's where we start thinking of aging when we are about 85 or so or that last stage, that's where the aging

starts. But before that, nothing happens. It seems. And of course, lots is happening then. (P17)

Personal acceptance promoted a sense of closure for participants who recognized a need to move forward with their lives.

I'm really much more I would say just, what, this is who I am, I'm starting to be where, if you like me, great. If you don't, I don't care. To a certain point, I never probably ever gonna be 100% I don't care. But it's, it's more and I'm starting to kind of be like, you know what, this is all part of life and you need to be comfortable with. Anyway, I'm just feel like I'm starting to come into my own as I go through my 40s and head towards my 50s. (P09)

Participants came to define themselves on their terms, proving to other people and themselves that this was a time of strength and power. By embodying strength and confidence, participants defy dominant discourses of the menopausal transition in the workforce.

...being comfortable with who I am. Embracing all the knowledge that I do have. Because I have that life experience, as well as, as well as you know, the knowledge but the life experiences and learning how to value that. (P06)

In sum, by engaging in spaces not designed for people in the menopausal transition, some participants understood menopause as a social creation. In turn, these experiences suggest how limited understandings or expectations of how menopause impacts individuals and that these expectations dictate social practices and work environments as they relate to menopause.

6.6 Chapter Summary

The embodied experience of menopause was a strong theme throughout the participants' narratives as they expressed concern about the unpredictability of their bodies and their changing

identities were key issues impacting participants in this research and their overall sense of health and wellbeing. In addition, they spoke about the impact of the invisibility of menopause and their desire to normalize the transition across home and work. The silence impacted their perceptions of their body.

Participants used power and agency to challenge different social discourses, binaries and meaning(s) about and of their bodies. However, these discussions and reflections were challenging, and participants expressed frustration, sadness, confusion, uncertainty in negotiating an understanding of their health and wellbeing.

However, there was also a reclaiming of power through language and their sense of responsibility to the younger generation to remove barriers, challenge the stigma and find a voice for aging women in the menopausal transition. In addition to heightened feelings of confidence and a sense of accomplishment, few participants revealed that being menopausal came with a greater appreciation of themselves. Despite the challenges, participants shared that the menopausal transition evoked a greater appreciation of their bodies and their relationship with their workplace.

Chapter Seven: Navigating Supports

"What do people need on the job site to be their best self?" (P25)

7.1 Chapter Outline

In this chapter, I present the findings aligned with the third research objective that document the perceptions of existing structural support(s) in the workplace shaping physiotherapist's experience with the menopausal transition. The chapter begins by highlighting the overarching theme of navigating supports by reflecting across the micro, meso, and macro levels for physiotherapists experiencing the menopausal transition in the work environment. The sub-themes contributing to this overarching theme are 1) reflective practice, 2) community of support, and 3) institutional structures. The chapter concludes with a summary of the findings of this objective.

7.2 Overarching Theme: Navigating Supports

With an increasing number of employees going through the menopausal transition, this research recognizes the importance of understanding the impact of perimenopause on work and the significance of work on the menopausal transition. Understanding the work environment and the support required is critical for a healthy workforce. The health care team, manager, institutional policies, and patient relationships impacted each participant's unique experience with menopause.

> *It's just knowing, what do people need on the job site to be their best self, and not everyone is gonna need the same thing. (P25)*

Three connected and overlapping narratives emerged when exploring the institution's structures and supports. First, the significance of the reflective practice as a health professional created opportunities for participants to view their individual and collective roles in influencing

change in the institutions and their profession. This new phase of work saw participants deepen their identity as experienced physiotherapists, a mentor, and an expert. Participants described the menopausal transition as a time for reflection, a time for questioning their relationship with their work, a time to both find their voice and become comfortable with this it, and a time where they prioritized their needs. Navigating time during the menopausal transition and their roles and responsibilities at work was significant to all participants.

Second, a community of support with new alliances developed during this time with colleagues, managers, the organization, and patients. New meanings emerged with allies as they supported each other and talked through the challenges of menopause in the workplace. Many physiotherapists identified patients as allies in helping them normalize the menopausal experience at work.

Third, participants reported a disconnect between how they manage their symptoms and the expectations to perform at work. Their symptoms did not align with the organization's deadlines, priorities, and schedules. For example, unpredictable hot flashes or severe bleeding could impede their ability and the time required to do daily tasks (i.e., manage patient caseload). Participants reported that navigating these institutional structures and reconciling the differences required patience, creativity, and flexibility to make them feel more relaxed, productive, and valued at work.

7.3 Subtheme 1: A Reflective Practice

Participants discussed this time as an opportunity to reflect on their career trajectories. Overall, they talked about discovering a renewed sense of self within their work. The menopausal transition was credited for creating space for this reflection and an opportunity to make meaning of their lives and their role in the workplace.

Before exploring their role as a physiotherapist going through the menopausal transition, many participants focused on their experience with aging. As a result, two narratives emerged, with the first exploring the positive lens through which they saw "*aging as a blessing*" *(P15)* and "*aging also means a lot of wisdom" (P12).* In contrast, the alternative narrative was a sense of denial, fear, and recognition that death is closer to them.

> *I don't often think about death in my life. And I think it's a good thing to think about death because it helps you to live better, right? But suddenly, it freaked me out. It felt really, it felt really real and close to me, as before, every time I thought about that, I was like, Oh yeah, I'm not scared of dying or whatever. That's fine ... I was like, Oh my god, I'm getting older and I'm gonna die and I panicked. So yeah, it is, totally, it's the sign of aging, right? (P19)*

Participants equated the menopausal transition and aging to the same journey that allowed them to grow, find a voice, and exert their confidence and wisdom within the workplace.

> *Whether it's exactly tied to perimenopause, it is certainly through aging and living life and gaining experiences and surviving going through hard times and surviving and coming out and learning from those things. So I do feel like I learned better and learn more now. I think that because I'm able to be kinder to myself to look after myself. (P29)*

This narrative of being *"kinder to myself"* was reflected in all participants' stories, notably as they considered their career journey and relationship within the workplace.

> *I also feel with that my hormones have changed where, as I'm a bit more selfish, and not in a bad way. But more instead of putting other people first realize sometimes like,*

no, that's not the best thing for me. And so I, I found aging actually, I've been quite happy with it. (P15)

This relationship in the workplace changed for some participants as they felt that age gave them a new level of respect in the workplace.

I started out looking like a kid, so didn't get the respect that I really felt I should get. So I was pretty happy when I started to look older. And, and would therefore garner some respect and for the wisdom and experience that I had, so I'm not, I mean, I, I'm good with aging. I don't have a problem with it. (P16)

Rediscovering the self as an aging, wise and experienced health professional was key to many participants, expressed through their growing self-confidence.

The other piece was being comfortable with who I am. Embracing all the knowledge that I do have. Because I have that life experience, as well as, as well as you know, the knowledge but the life experiences and learning how to value that. That's, that's sort of where I'm at right now. (P06)

This self-awareness and self-confidence grew over time, and participants knew the accumulation of experiences allowed them to grow in their clinical confidence, find a voice to advocate for their patients, and be engaged team members.

I've had other physios mentor with me and they would always ask me what course did you learn that in? I tell them stop asking me because it's not A course. It's an accumulation of all my education and work. (P12)

While participants spoke about the hidden nature of menopause in society, they recognized their role and responsibility to "*make it more normalized and not a secret*" (P09). Participants were passionate about taking a lead in this work by raising awareness to make the invisible

visible and infusing menopause into our language, conversations, and lives. At the same time, there was a desire to create a supportive community that includes the constructs of age and gender in the workplace. As part of this rediscovering of self, participants valued their new role as a mentor, coach, teacher, and resource for their team. *"Embrace your wisdom, you worked hard to get there" (P06).*

> *I find that I'm more confident with myself and that I'm more willing to just listen to others. But if I have something to say to say it and yeah, I think I feel respect from my peers (P15)*

Participants acknowledged their role as leaders in influencing change in the workplace as others (particularly male colleagues) were not going to be the voice or change agents.

> *I really wanted to do, but I still I want to do a revolution. Like I'm like, we need to change things here like we need to, and it's not the guy that are gonna change it for us. So, we need to do something because we're not at the beginning of the 1900s anymore where most women died before it happen. We're spending almost half of our life in this and we have to, we need to develop a better positive image about it, right. (P19)*

A recognition that menopause is an integral part of aging and the menopausal transition.

> *But as I get older, I'm like, Yeah, I know. I've got a little bit of socks, I got some socks in the drawer, so to speak, or I've got some mileage on my shoes, right. (P20)*

Participants' concerns spanned functional, professional, and systemic areas, including altering the fundamental perception of oneself. For example, participants identified how menopausal symptoms impacted their sleep, energy, memory, cognitive functioning, and overall

mood. In addition, they were concerned that their symptoms could impact how they performed at work and their performance assessment.

> *if someone's not able to come to work today or having difficulties processing all that's going on in the room. I feel that that could come down to someone wondering whether or not you have capacity. Sweating, doesn't that sweating to me, or having a hot sweat isn't about competency, but having brain fog, having difficulties managing large volumes of work, being able to come to work, engaging in the way that you know, we're supposed to engage. Those are vague symptoms are vague, that could be attributed to performance. (P20)*

Participants were concerned about the repercussions of participating in the research and the results used to disadvantage menopausal physiotherapists negatively.

> *Why would they be studying physiotherapist in menopause, they're probably trying to prove that we're incompetent, that we are like, emotionally unstable, and that we should retire. We shouldn't be allowed to work when we enter menopause. (P28)*

Many participants felt a personal responsibility to negotiate their health and wellbeing within the work environment.

> *So, I think just having that ability to just be who I am at that moment, knowing that I also need to not take it out on anybody. And I don't have that right to be grumpy. Because I'm at work I can I need to be able to deal with that. And for me, it's always been like that, if I'm misspeaking or in a way that is unpleasant for other people, then I need to nip that in the bud. And I have enough self-awareness that I'm able to do that. I don't know, you know, you live long enough, and you develop some of these skills, or you suffer, and I don't choose to suffer. (P26)*

All participants spoke about their passion for the physiotherapy profession and their commitment to patients' health and wellbeing. However, many participants questioned the capacity of the health care system to support aging physiotherapists. The challenges in the profession became apparent and, at times, untenable as participants managed work with menopausal symptoms. Participants referenced the systemic barriers within society and work, particularly from the perspectives of gender and age.

> *Being a woman going through those changes as a health professional is nasty. So, that way the society in general is not supportive for that, it's systemic a little bit here. (P18)*

The notion of change highlighted how participants made comparisons (positive and negative) with aspects of past and previously established identities. These changes influenced decisions about future engagement with work or a transition into retirement.

> *Because it is a transition, and it's the whole goal is that we're transitioning not to who I used to be, but to something better than ever, but it is...there's ups and downs along the way and trying to navigate that and ask for support when you need it and ask for space when you need it. (P04)*

They were renegotiating identity aligned with participants' sense of meaning at work. Having a sense of purpose, giving back to the community, and supporting health goals for patients were essential elements that framed the identity of participants. As part of aging and the menopausal transition, participants were surprised that their relationship with work was changing, including their motivation.

> *My colleague who's the same age as I am, she's looking at retiring here in a year and a half too because we just don't have the empathy and the compassion for our patients. And we want to, but where the tank is getting empty because of the longevity*

of the career now she's got a family and such, but I don't and I still feel that way. So I you know, I don't know that menopause is entered into that. I think I would feel Yeah, well, I mean, I can't imagine being at this point in my life without menopause. I would still be tired. (P26)

While many participants stayed in their work setting for decades, they changed roles and maintained their training and current knowledge through continued professional development across their careers. Participants were dedicated to being a physiotherapist and struggled to understand this change in motivation and the new focus on the end of their formal paid employment.

It's hard for me to kind of be half into work or half into a job. And so, it's such an unusual shift for me at 52. Now I just turned 52 to be thinking more about retirement than I am about what my current, my next career goal will be. (P20)

Participants reported that personal factors (i.e., menopausal symptoms) negatively affected their motivation and commitment to work and increased their intention to leave the workforce. Retirement was viewed as an opportunity to disengage without having to disclose the impact of their menopausal symptoms on their performance.

I know for me, sometimes, like, I'll say, "Oh, my God, you know, I should retire soon". Because cognitively I don't have what it takes, or I can't learn things as much, and blah blah blah, and I find solace in the fact that I'm getting closer to retirement. (P28)

Structural elements, such as a pension, lack of flexibility, and work pressures, were identified as additional factors impacting participants' relationship with work. Some

participants felt trapped in their positions as they did not want to risk losing their benefits, including their pension.

> *I'm not changing my job. I'm not, because I want my pension. I'm going to continue in this and every time I get my pension thing, I'm like, okay, when can I retire? I talked to my husband, because having done direct patient care since 84, is exhausting. (P26)*

There was a spectrum of perspectives from participants who understood retirement as a phase of decline to participants who viewed it as a phase of enjoyment after a life of hard work.

> *So if you're not comfortable, like I understand if you can afford it, you know what, I'm walking away. I'm taking some time. I don't want to do this anymore. (P05)*

This sub-theme highlighted that perimenopause created space for a new relationship with work. Participants recognized their new identity as experienced health professionals valued as mentors with perspective and wisdom. However, as participants explored this transition in their identity, they raised concerns about the health system's capacity to support their new identity. For some participants, the institutional and structural limitations influenced their decision to explore alternatives to their current employment, including leaving their role, starting a business, or transitioning into retirement.

7.4 Subtheme 2: Community of Support

This sub-theme highlights the alliances and allies in participants' workplaces that emerge throughout the transition to menopause, including colleagues, team members, management, and patients. While physiotherapists work in a variety of settings (academic, private, public, military), the significance of supporting each other was pivotal to all participants. Although not all participants believed they worked in supportive and inclusive settings, many were part of

long-term relationships and comradery within their health teams. In addition, participants reported that respect and being heard for their individual needs were a priority, particularly as they entered the menopausal transition.

> *It's about having an open and loving workplace that talks to people about their individual needs, and really understands that their individual needs for health are not just physical, they're also psychological. (P20)*

Many participants worked in their clinical setting and with the same team for ten to twenty years, building a sense of family as they went through similar life experiences at the same time (i.e., pregnancy and child-rearing). The importance of talking with colleagues becomes a "*sort of support group, and just some safe space to share stories and struggles*" (P11).

> *Menopause is one of those things. It's, there's a group of us at work that we're all in similar age categories. And I think we're, we've always been open like we've, a lot of us got pregnant together, a lot of us had our babies together, a lot of us are going through the teen years together. And now we're all in that stage where we're kind of transitioning to menopause. (P09)*

A key success factor for some participants was a strong team and effective leadership within their work. This team was not only physiotherapists but also other health professionals and administrative staff.

> *Every place that I've been, I've been working with a good crew of people. You know, good teamwork. And I've had reasonably good supervisors, some really, really great supervisors sometimes. And that has made all the difference in the world, (P01)*

However, several participants noted the gendered aspects of the work environment, mainly when they reflected on leadership and management. Some participants felt a female leader would create a culture where menopause becomes discussed within the team.

> *I've worked at clinics where males were bosses. And that was never something that was brought up. I guess, female bosses would be more open to these conversations. And, you know, talking about self-care. (P05)*

Other participants witnessed a lack of support from women, particularly female leaders.

> *They [female leaders] are women raising children. And I feel like there's a bit of a "it wasn't available for me. So why should I make it available for you" which I find such an unfortunate way to think about it. Right, instead of "it wasn't available for me, gosh, darn it, I want to make sure it's available for others." (P08)*

Many participants reported that their colleagues were vital for continued engagement with the institution. In addition, the lack of support from management during perimenopause was a concern for many participants.

> *At our workplace, I do have to say we don't have a very supportive management. But I think the only reason I stay is the colleagues, they are just incredible, they're really good up to date physios that just are so keen to keep learning and, and the patient care is amazing. And so, I think that's what keeps me there is the support from colleagues, not the management, yes, we could be much happier without them. (P08)*

Participants identified systemic challenges as they referenced that the busy clinical environment was not conducive to supporting individual physiotherapists. In addition, participants recognized that colleagues may have difficulties throughout the transition but cannot

seek support, advice or guidance as there is limited time and awareness of the perimenopausal journey.

> *Women feeling alone. Feeling like they're struggling with the, the both the physical and the mental health aspects of perimenopause not knowing what it is. And in many of them in clinical environments, where it's a busy, fast paced environment. (P11)*

Participants' continued commitment to an inclusive workplace was a standard narrative, and they were determined to use their experience to influence change within the physiotherapy community. In addition, they valued being leaders in changing the silence in the workplace. They believed this role was essential to prepare the younger generation in their personal and professional lives for the menopausal transition.

> *My younger colleagues will be much better prepared as a result of what I've talked about. Because when their time comes, they'll have had the experience of having somebody talking about it. (P01)*

Many participants identified patients as critical allies in the workplace. Often the patients were individuals who were postmenopausal or in the transition phase. They provided words of support, advice and encouragement that made participants *"know that you're not the only one that goes through that stuff." (P14)* Some participants were surprised by this support as it may have been the only person who normalized the experience and permitted them to take a moment at work to adapt to their symptom(s).

> *It's amazing how supportive our patients often are, actually, yeah. It's the gratitude that they get from what we do for them, right. They realize how much they achieve because of us. They feel always so grateful. (P08)*

If my menopausal women are in, they completely understand and they're very understanding. They're like, "No, no, I trust you know, just keep going. When the word comes to you. Just let me know". They've been very helpful and supportive. I think that that's, yeah, women supporting other women. That's been critical. (P06)

A supportive space was valued, yet there was recognition that the profession's culture is not always willing or skilled to discuss and support individuals through the menopausal transition.

There's a lot of physios that go through menopause. A lot of them. A lot of them doing right now... this year. But yet, it's not necessarily something that we do a great job of talking about and supporting one another. (P04)

Some participants expressed disappointment with management when there was no support during the menopausal transition at work.

When I talk to my physio boss about support. It was basically that I'd have to apply for disability to get accommodations at work in this whole big paperwork process. When in retrospect, what should have been said to me at that moment is like, "oh, my goodness, you're having a really hard time right now. You have sick time and that's what it's for. Take it, a few days off" (P03)

The lack of support was perceived to be outside the individual level of the manager but embedded within the systemic structures of the organization and health care system.

I met with my boss three times, and just saying I can't do this. I don't know how to make this work; I need to work less. And three times my boss said, "you're gonna have to make it work. Everyone else makes it work. We can't cut you back anymore". I was, I don't know how many hours I was working. But I was there five days a week.

And I was doing, I was treating patients for six hours a day. So anyway, so I really didn't feel supported. (P04)

This sub-theme highlighted the emerging allies and existing alliances in participants' workplaces throughout the transition to menopause. The significance of supporting each other was pivotal to all participants, who reported that respect and being heard for their individual needs was a priority. Patients were foundational for some participants as this support may have been the only person who had normalized the experience and permitted them to take a moment at work to adapt to their symptom(s). On the other hand, some participants expressed disappointment in the lack of support and betrayal by the institution for the lack of flexibility to create a safe space for their employees within a health care setting.

7.5 Subtheme 3: Institutional Structures

This sub-theme highlights participants' perception of institutional support to create inclusive and safe spaces for employees undergoing the menopausal transition. Participants expressed concerns ranging from the lack of awareness about menopause to their physical discomfort exacerbated in the work environment. Participants focused on the importance of flexibility throughout their careers yet recognized that challenges within the current health care system strain on managers and, ultimately, the healthcare teams.

At the beginning of the perimenopause. I'm like, I cannot see that many patients like it's, it's just I'm so freaking tired, that I get home and I can't do anything. And it's impacting my life outside work. And how you do so you feel like all you do in your life is working. So, I think if I was 20 years old, again, I wouldn't be a physiotherapist just because of the fact that the way I find even being a doctor, if you see patients every five minutes and you have like, I think it's too much. I think the

health profession are overworked. So being a woman going through those changes as a health professional is nasty. So, that way the society in general is not supportive for that, it's systemic. (P18)

Some participants needed clarification on asking for alternative options to their dedicated work hours as they need to see a culture of support across the institution. Clinical expectations are clearly articulated and must be met to be successful.

If you've heard of other people that weren't supported, then it makes it even more difficult to go and say, well, like, say, for instance, we are expected to see three new patients, three patients and our one new patient every day. And, I mean, I still met that. But what had I ever got to the point where I would say, and this is not why I retired or anything like that. It was a decision I came to, but I don't think I would be supportive, supported, had I said, I need to reduce that to a certain degree. Yeah. Which is really unfortunate. (P23)

Many participants reported concerns about their ability to perform their job safely for themselves and their patients. Several participants spoke about their lack of sleep impacting their judgement, attention to detail and ability to perform their job safely with patients.

I'm going to drive three, over three hours that I'm going to see a bunch of patients, I'm going to turn around, drive back. And so even today, with the sleep I had last night, I was lying there kind of in bed questioning whether it was safe for me to go. Because it was, and I actually said to my manager, when it came in. I was I was nervous, like, I, and, when we when I went home for lunch to my husband. I said, I don't think I would have been comfortable driving today, because it's just too fatigued. (P27)

Participants explored the different experiences across the scope of practice and the various work settings (i.e., private, public, or military). Participants noted different expectations between public and private clinical work.

> *I feel like pretty well supported at that job. Ironically, in the more smaller organization jobs like working at the private clinic. Yeah, you're totally on your own there. Like that setup is your independent contractor and you literally just pay half of what you make to your employer. That's generally this setup. So there's really nothing, you rent a table, do your work, go home at the end of the day. Kind of no one asks any questions. No one really cares as long as your paying your half of the bills. Yeah, that's generally, there's really nothing. So yeah, if a woman was having some issues for whatever reason, and wasn't able to work for some period, or was really struggling at work, that would just be on her. (P07)*

Several participants spoke about changing their clinical practice as they aged and through the menopause transition. For example, participants spoke about treating children requires the ability to *"crawl on the floor,"* or working with adults means that you use your full body *"as part of treatment."* Participants felt that it is challenging to maintain this intensity within their practice and for their patients as they age and experience perimenopause.

> *There is a bit of ageism. And I've stepped away from sports injuries, because they want young and dynamic. And you can't feign that in menopause. So, if someone wants their kid to come for a sports injury to come my office. "Why don't you go to your university has a Sports Clinic, I think that would suit better". So, I really am, stepped away from that because there is a perception it's a young person's game. I don't know if that's ageism or that's menopause, combined together. I don't know if*

that makes sense? But I do tend to shy away from sports. Now if it's a very active rehab. I just give them a younger therapist. (P21)

Even if there was a space to take a break, the intense schedule does not allow time for physiotherapists to take additional breaks. In addition, scheduling is often out of the hands of the physiotherapist, creating added strain and pressure complicated by the complexity and uncertainty of menopausal symptoms.

The space I've got, I can only have one or two people in the space at a time. But everybody's on a schedule. So, if you know if I'm sweating and burning up and I can't stop and take a minute and cool down and, you know, get my head back together before I have to go and see somebody else so you just, you just have to push through it. (P14)

All participants spoke about their commitment to their patient's treatment plans and recovery. Unfortunately, the current healthcare delivery model in public and private care is viewed as a barrier to managing the uncertainty of menopausal symptoms. It is difficult to be flexible when the caseload is high, patients are waiting for care, and there are no additional health care team members who can fill in during your absence.

If sleep is an issue, it would be great to have flexibility right to maybe start later one day or to I guess could have called sick and take some sick day, but I just can't do this. So yeah, more flexibility in this case. Saying oh, I've gotten really tired I'm gonna leave earlier today or I'm going to come in later. Which is hard because we have clients that are booked right. My first client is at eight o'clock in the morning so I feel committed to those people I feel they rely on me and I need to show up (P19)

Some participants reflected on their role as a manager and how they supported their team by considering the whole person. By recognizing that their personal life may impact their work performance, participants created a safe space for their team to thrive.

> *I do think about when I'm in the role of manager, and when someone exhibits a behavior that is, unlike them. The way, I've had some pretty good mentors for that role. And their advice would be to find out what's going on in their life. Right, rather than jumping on the behavior, just step back a little bit and, and find out what's happening with them. So that would go along with that. Yeah, yeah. And so when you asked about how that would have affected, like, if I marry those two, right, that that advice that I was given plus my own personal experience, then it would be "What is going on? What's happening in your life?" You know that that provoked that behavior? That was just not you? (P16)*

However, some participants experienced managers who did not build relationships and focused on their position of power and authority. In addition, these participants spoke about women not supporting other women in the workplace as they focus on their daily responsibilities, do not take the time to mentor, or support the physiotherapy team.

> *I always tried to make sense of; are we harder on our own sex? Well, I did it why can't you do it? "Well, too bad for you. You suffer. I got through it. Suck it up." There was a suck it up attitude, which I don't think that goes anymore. I don't think a female will respond to suck it up anymore. And that I saw that a lot in my day, your granny died "well suck it up, you're still working on a weekend", I grew up with my granny living in the house and sorry for your troubled but suck it up. And I think, there was a little bit of that where you had a third child, well suck it up honey,*

instead of embracing it and saying, "okay, you're struggling, what can we do? What can we do to make this better, easier?" If you have a good worker if there's a worker who's slacking off and not pulling their weight, I'd have a different attitude. I might ask why. (P21)

A lack of awareness and poor knowledge of the menopause transition impacted participants' engagement in the workplace. Talking about menopause within the workplace was perceived as taboo, and there was limited awareness of support required for the transition to menopause. Some participants discussed how important it was to have sympathetic managers to negotiate these symptoms.

Being able to talk about it more or having more of a dialogue, or information available for every one of every age. Might, yeah, create a better comprehension around the topic (P28)

In many work environments, participants referenced the health care team as key to their careers. Some teams were primarily included occupational therapists, but many of the teams focused on the relationship with nurses and doctors. All these discussions were gendered and focused on the power structures embedded with the health care system.

all the physicians I worked with were doc's were males around my age. And it's kind of, like you have a hot flash and you can feel yourself flush. And then you start to blush because you're flushing, which just makes it worse. And I don't know, like, I guess. I think I even said to them, I'm having a power surge. I just, you know, we had all kind of grown up together. All the physicians had all… a new set of physicians had come in to work shortly after I had started there. So, we were all of the same kind of age, age group. But it was, it was a little embarrassing, because it feels like it

feels like a blush when you know, it's not a blush. It's a flush, you know? So yeah, it was a little bit embarrassing. But it's a fact of life. (p16)

Participants wanted employers and managers to have more knowledge and awareness about menopause and identified the need for ongoing professional development. In addition, participants believed that this training would help managers support employees experiencing menopausal symptoms.

There's so little known and so little attention and so little, embracing that. People talk all the time about their total knees and total hips and how the surgeries this and the surgeries that and we have special programs for them in the Rec Center. But we're not ever talking about menopause (P17)

Meanwhile, participants questioned if the training would be inclusive of gender, aging, and the menopausal experience. In addition, they recognized gaps in the current curriculum, professional development, and employee training.

I used to do some presentations on the challenges of an aging workforce. Obviously female employees and perimenopause might have been alluded to but it wasn't research that I would have put into other challenges that are faced by employees at age. I hate to say it, but maybe it's because it affects woman more than men. We don't have much information available. (P29)

Participants reported that unpredictable hot flashes or severe bleeding meant that they might take longer to do their work or make patients feel uncomfortable. In addition, they identified that the physical environment (i.e., clinic, hospital, classroom) did not have space to take care of their menopausal needs. For example, in some cases, the washroom was not on the floor where they were working, making it difficult to leave the patient to tend to their physical

needs. In addition, many physical settings needed to be organized with proper ventilation, lighting and space to take a break when needing a few minutes for recovery.

> *...have a space where you can sit privately, yes. But you know, your patient is at 10 o'clock. You have to be there at 10, you can't call in while I'm having hot flash. There is no leeway. I mean, that is also the patient is there. So, you can't say to the patient, "okay, I'm sorry, but it's not working today". (P17)*

Transitioning back to work with new public health restrictions added concerns about how to manage menopausal symptoms in the clinical setting.

> *If I was on the ward, and that happened, I don't know what I would have done. So, I'm going to have to figure that out. Because on the ward, especially now with COVID, we travel as a minimalist unit, if I have a patient list, it's tucked away in a pocket where it can't get contaminated by an unwashed hand and all the rest of it. So, I don't know, like extra feminine hygiene products, would they fit in a pocket in my scrubs? Maybe. Would I wear my black scrubs? Definitely. (P07)*

All participants identified flexibility as the key to their health and wellbeing. Flexibility included work adjustments such as changes to sickness/absenteeism procedures, increasing rest and break times, modifying work hours, and reducing the number of days required at work.

> *Having flexibility in the workplace, if you need perhaps, you're going through a difficult transition, like maybe you're not sleeping, and you've tried everything, like maybe it's trying to find a flexible work day schedule, or it's being able to work fewer hours or being able to have a different type of pace, or caseload or something like that, that just having that flexibility (P09)*

Many participants mentioned wanting to transition to part-time or reduce their work hours to take control of their health and find work-life balance. However, they wanted to avoid putting their colleagues under an additional pressure since their position would not be replaced in the current healthcare climate.

> *I think that would probably be the biggest thing for people they felt overworked as well. We're chronically understaffed. And so being overworked, exhausted, because you're not sleeping well at night. I think that plays quite a toll on people. So having the flexibility to move to fewer hours or even you know, just that one day a week I think makes a huge difference for people (P08)*

The availability of formal and informal support was vital for physiotherapists to navigate through the transition successfully. Working with a team aware of your health needs and can "*have your back*" (P20) when you have unplanned needs is an essential part of this support.

> *Having the flexibility to either work at home that day, or I know it's not possible when you're seeing patients, but in other workplace settings, it would be nice to be able to have that. Or just even support like, okay, you come out of your treatment room and you're like, "I gotta go change something right now". And they're like, "no worries, we got it. Go do it." You know? That's certainly more just yeah understanding and support around what's going on, but it's actually a really big change that you don't really have a lot of control over. (P06)*

Some participants spoke about working part-time when their children were young, but they did not believe these opportunities were available as part of the menopausal transition. In addition, there were few examples within the work environments of flexible

hours and a perception by most participants that the organization would not support this type of flexibility.

> *Then it's balancing long days at work. So now I'm actually thinking, oh my God, I wish I could work three to four days a week, to me, it would be a good balance with where my life is right now and how I feel in my body. But it's not how it works. Well, it could be if I decided to quit. (P18)*

Throughout the interviews, participants reflected on institutional supports available for menopausal employees. Three participants acknowledged employee assistance programs as a potential resource but had yet to use them. All participants took a moment to reflect on the question and had not thought about how the institution could support them through this transition.

> *I worked a lot with employers too, and I have never really that's not a conversation that has been raised to be honest, like, about how to help or support perimenopausal employees or. And program that they could offer, like, a lot more interest in mental health within employers in the last 5 years. I never heard it spoken, like, specifically related to menopause. (P29)*

This sub-theme highlighted participants' perception of the need for institutional support to create inclusive and safe spaces for employees undergoing the menopausal transition. Participants reported that navigating these institutional structures and reconciling the differences required patience, creativity, and flexibility to make them feel more relaxed, productive, and valued at work. Participants focused on the importance of flexibility in their careers yet recognized the challenges of creating space for this flexibility within the current health care system.

7.6 Chapter Summary

The collective narratives shared three directions when exploring the structures and supports within the institution. First, this time of transition for perimenopausal physiotherapists created space for a new relationship with work. Participants recognized their new identity as an experienced health professional valued as a mentor with perspective and wisdom. As participants explored this transition in their identity, they raised concerns about the capacity of the health system to support their new identity. For some participants, the institutional and structural limitations influenced their decision to explore alternatives to their current employment, including leaving their role, starting a business, or transitioning into retirement.

Second, participants reported a disconnect between how they manage their symptoms and the expectations at work. There was a perception that institutional supports were needed to create inclusive and safe spaces for employees going through the menopausal transition. Participants reported that navigating these institutional structures and reconciling the differences required patience, creativity, and flexibility to make them feel more relaxed, productive, and valued at work. Participants focused on the importance of flexibility in their careers yet recognized the challenges of creating space for this flexibility within the current health care system.

Third, new alliances emerged with colleagues, managers, the organization, and patients during this time. Supporting each other was pivotal to all participants, who reported that respect and being heard for their individual needs were a priority. Patients were foundational for some participants as this support may have been the only person who had normalized the experience and permitted them to take a moment at work to adapt to their symptom(s). On the other hand, some participants expressed disappointment with the institution's lack of support and betrayal in creating safe spaces for their employees.

Chapter Eight: Discussion and Conclusion

8.1 Introduction

The research aimed to increase understanding of the gendered dimensions of health and wellbeing concerning the transition to menopause within the work environment by using a case study of Canadian physiotherapists. Informed by feminist geography and engaging qualitative methods to address the following objectives: 1) to examine the relationships between aging, gender, health, and wellbeing in the workplace, 2) to explore the experiences of perimenopause for physiotherapists in the Canadian work environment, and 3) to document the perceptions of existing structural support(s) in the workplace shaping physiotherapist's experiences with the menopause transition.

In the findings chapters (Chapters 5 to 7), I presented the participants' experiences related to the research question and the objectives using feminist geographies to explore and understand the beliefs, values, perspectives, and practices that influence Canadian physiotherapists' transition to menopause in the workplace.

The first section of this chapter discusses the three themes within the findings contextualized within the current literature on perimenopause in the workplace: 1) exploring being well at work, 2) the embodied experience, and 3) navigating supports. This discussion also provides an opportunity to consider the findings within the context of the research objectives. Furthermore, the chapter identifies the main contributions of the research, discusses the policy implications for the findings, and concludes with limitations guiding directions for future research.

8.2 Key Findings

The findings uniquely add to the body of literature on perimenopause in the workplace, specifically the experience of health care providers. In applying feminist geography, I examined how perimenopause is experienced and understood by physiotherapists.

8.2.1 Exploring Being Well at Work

This research qualitatively explored physiotherapists' experience with perimenopause in the workplace. In doing so, I aimed to increase my understanding of the meaning of health and wellbeing in the workplace. More specifically, this work investigates the experiences of Canadian physiotherapists in public, private, military, and academic workplaces. I ensured that the voices represented a variety of roles in the profession, including clinical, management, leadership, research, and teaching. This work applied a broad definition of health (Elliott, 2018) and wellbeing (Deaton, 2013) to understand the factors contributing to wellbeing at work. Throughout the research, participants extend the WHO Commission on Social Determinants of Health as a framework recognizing the role social factors (i.e., non-biomedical factors) play in shaping the health and wellbeing of individuals and populations. Participants sought to understand the relationship between being well at work and power, intersectionality, and shifting relationality (Holman & Walker, 2021; Hankivsky & Christoffersen, 2008).

While other studies explored symptoms and treatments of perimenopause (Trudeau et al., 2011; Duffy et al., 2012; Im et al., 2010), this research increased our understanding of health and wellbeing through the experiences of perimenopause in the physical and sociocultural environments. Elements of the physical environment are relevant. However, attitudes and behaviours to aging and menopause are grounded in the sociocultural environment. This research

emphasizes how the combination of sociocultural and biomedical factors influences the experience of perimenopause in the workplace.

A key concern in the literature is the wellbeing of health professionals and the impact their health can have on the quality of care and patient safety (Dza, Kirch & Nasca, 2018). All participants in this research highlighted the importance of feeling well to perform their job. All participants prioritized self-care, recreational activities, and overall wellbeing by establishing and maintaining work-life integration. The physiotherapy profession promotes a healthy lifestyle, prioritizing an active lifestyle throughout life (Hay et al., 2014).

This research concurs with previous studies focusing on the adverse effects of perimenopausal symptoms on quality of life (McVeigh, 2005; Im et al., 2008; Dare, 2011; Jurgenson et al., 2014). However, few studies focus on symptoms and their impact on employees and the workplace. Therefore, the findings from this research provide additional knowledge about the experience of perimenopause in the workplace. Specifically, the findings showed that the relationship with being well in the workplace changes over time. Participants were unprepared for this change and modified their work to ensure they could sustain their energy at work and in their personal lives. The work-life integration was challenging to maintain as they aged, with many participants creating a deliberate divide between work and home responsibilities. Many participants modified their approach to work by leaving on time, not taking work home, and accepting these boundaries.

This research highlighted the concerns of physiotherapists about the impact their health would have on the team, the quality of care and the health outcomes of their patients. A lack of awareness and poor knowledge of the menopause transition has a negative impact on productivity (Hammam et al., 2012). Participants depended on their social support and

normalized asking for help with child-rearing and caregiving roles. However, as they aged in the workforce, there were fewer peers and limited opportunities to discuss perimenopause in the workplace. The lack of discussion about perimenopause increased their knowledge gap, contributing to workplace silence about this significant life stage. Peer support and space to actively seek collegiality to reduce isolation were limited and more challenging to find in the work environment.

An etiquette of keeping menopause hidden enables negative narratives to persist unexamined and may result in individuals entering menopause with partial information and few positive role models (Seargeant & Rizq, 2017). In addition, research participants referenced their lack of preparedness in another study (Hamman et al., 2012).

The data suggest that perimenopausal individuals need the information to interpret their changing bodies and make choices about their responses. This information balances the variety of perspectives of perimenopause by making visible cultural narratives, the lived experience, and the biomedical experience. These different perspectives create awareness for perimenopausal to construct a positive narrative and to feel confident in this life stage.

This research goes beyond perimenopause in the workplace and investigates how health care professionals understand and manage the sociocultural and physical context of aging in place. In Chapter Five, three interrelated sub-themes highlighted the significance of this finding; 1) finding balance, 2) transformative experience, and 3) redefining their value. The in-depth interviews allowed the lived experience to be visible and validated, while they also developed an understanding of gendered health and wellbeing in the workplace.

8.2.2 Embodied Experience

The embodied experience reflects beyond the physical aspects of menopause to explore the invisible dimensions of the transition and their impact on physiotherapists in the workplace. I will explore and critique the research findings in the context of the literature as it relates to embodiment and perimenopause.

While certain findings complement what was previously described in the scholarly literature (see chapter 2), feminist geography allows the participants' stories to be visible and validated. In addition to gender, this research captured age as another identity of difference (Krekula, Nikander & Wilinska, 2018). Aging is a dynamic process (Segal, 2013; Toni & Calasanti, 2006; Sandberg, 2013), but it is not explicitly the focus of feminist geography (Finlay, 2021). Theorizing more explicitly how different actors socially construct age exposes inequalities and provides evidence for policy recommendations (Skinner et al., 2015). This research focused on gendered aging through midlife as a distinct social group within the workplace.

Throughout the interviews, all participants expressed concern about their changing bodies. For some participants, the interview only focused on the perimenopausal body and the uncertainty these changes presented in their work life. As participants became comfortable in the interview, their stories expanded to the emotional, mental, and cognitive changes as part of perimenopause. These changes were still viewed and experienced as emerging from within their body and recognized as connected to hormonal changes. The body was a central theme in all interviews in which new priorities, new identities, and a recognition of a renewed role in society and work emerged. This work shows us how there is a new way of creating meaning and understanding of the body and identity through the transition to menopause.

For all participants, the changes were unexpected, and they felt unprepared for this midlife phase. This lack of preparedness is discussed in another study (Marnocha et al., 2011), while additional studies note the distressing effects of the symptoms (McVeigh, 2005; Jurgenson et al., 2014; Im et al., 2008). Some participants in my research and other studies (McVeigh, 2005; Jurgenson et al., 2014) were pessimistic about the changes to their bodies. In this research, five participants did not have severe symptoms and felt they were "*lucky*". Other studies found that perimenopausal symptoms were minimal (Yisma et al., 2017) and uneventful (Lim & MacKey, 2012), and participants felt optimistic about the changes (Im et al., 2008). For participants in this research who found the symptoms difficult, the focus was on the extreme changes in their mental health and cognitive decision-making. There are no studies related to physiotherapists' experience in perimenopause. However, a study of Japanese perimenopausal nurses (Matsuzaki et al., 2014) reported an association between work stress and menopausal symptoms, especially related to concentration and mood.

There are limited qualitative research studies about the impact of perimenopause on the quality of life (Matthews & Bromberger, 2005; Whiteley et al., 2013; Li et al., 2000; Nguyen et al., 2022; Wang, Ran & Yu, 2019). Researchers have yet to explore the individual experience of perimenopause resulting in an incomplete narrative and understanding of the transition (Birke, 2000; Beck et al., 2020). This incomplete perspective emphasizes the biomedical model, which focuses on independent symptoms and body parts (Alaimo & Heckman, 2008). The body interprets the relationship with the world (Leder, 1990) and is essential as the centre for the perimenopausal experience. The participants in this study highlighted the importance of the body and mind in the interviews.

The body is constantly engaged in the world, and body changes can impact how the world is experienced and how the body experiences the world. Health care professionals respond to patients' health needs by using their bodies (hands, eyes, ears, mind) to diagnose and treat disease, illness, and disability (Kelly et al., 2019). The contribution of the mind and body among health professionals as central to their role and performance has not been understood or researched to date, particularly concerning aging and menopause in the workplace (Mensinga & Pyles, 2021). This relationship with the body personally and professionally significant to a physiotherapist. Through the engagement with physical bodies, physiotherapists provide health care to improve the mobility and wellbeing of patients.

Throughout the interviews, participants reflected on the physical changes of their bodies, their lived experiences, and making sense of these perimenopausal changes. James and Hockey (2007) frame embodiment to integrate biomedicine approaches and social constructionism. By integrating these approaches, embodiment offers a framework beyond the duality (e.g., mind-body) of the bodily experience (Katz, 2013; Csordas, 1994). This framework supports the lived experience and narratives of the research participants allowing a holistic view of perimenopause (Dillaway, 2006).

As embodied beings (Merleau-Ponty, 1962), the changes in our bodies affect how we feel about ourselves and how we interact in the world. Silencing the body creates a loss of agency (Kringen & Novich, 2018) which is reflected in the perimenopausal experience as participants feared disclosing menopausal status (Brewis et al., 2017) and recognized that this life phase could impact their work performance and career opportunities (Atkinson et al., 2015)

The embodied experience research finding focus on the unpredictable body, exploring the invisible, and normalizing the transition. Participants' experience taught us about living in and

with their bodies through the transition to menopause is a changing, evolving process. Through this research, there is a growing appreciation for the spectrum of ideas which are both fluid and overlapping as we embrace the lived experience, agency, and an expansion of the mind-body dichotomy. Thus, an embodied approach that attends to biomedical and social constructionist ideas may help deepen our understanding of the menopausal transition in the workplace.

8.2.3 Navigating Supports

The research documented the perceptions of existing structural support(s) in the workplace shaping physiotherapist's experience with the menopausal transition. I will explore and critique the research findings in the context of the literature as it relates to workplace supports and perimenopause.

The literature complemented findings from this research in relation to individual coping strategies including sleep hygiene (Verdonk et al., 2010), dressing in layers and modifying the physical work environment to manage hot flashes (Fenton & Panay, 2014), work with lists to mitigate memory issues (Kopenhager & Guidozzi, 2015), and explore lifestyle changes related to diet and exercise (Kopenhager & Guidozzi, 2015).

However, the findings from this research also reflected that many institutions continue to perceive menopause as a taboo topic (Whiteley et al., 2013) and employers have limited awareness of supports required for the transition to menopause (Viotti et al., 2020; Williams et al., 2009; Sarrel, 2012). A lack of awareness and poor knowledge of the menopause transition has been shown to have a negative impact on productivity (Hammam et al., 2012). In addition, Brewis et al. (2017) discovered a fear of disclosing menopausal status as there is a perception that it could limit career options and growth (Atkinson et al., 2015). Some participants raised

concerns about the findings of this research being used by regulatory bodies and employers to reprimand and monitor performance of menopausal physiotherapists.

A recent narrative literature review (Verdonk et al., 2022) concluded that menopause continues to be unrecognized and unaddressed within work environments. We saw how participants challenged the discourse and were passionate about taking a lead in raising awareness to make visible the invisible and by infusing menopause into the language, conversations, education, and work environments. Participants taught us about the importance of developing curriculum for entry-to-practice and professional development for physiotherapists specific to the transition to menopause (Rees et al., 2022).

The findings from this research complement Griffiths et al (2010) who concluded four areas to be addressed in the workplace (1) menopause awareness among supervisors, (2) flexible schedules, (3) access to resources and information, and (4) environmental changes in the workplace. Participants reported a disconnect between how they manage their symptoms and the expectations to perform at work. Their symptoms were not always in line with the organization's deadlines, priorities, and schedules. Unpredictable hot flashes or severe bleeding could impede their ability and the time required to do daily tasks (i.e., manage patient caseload). Participants reported that to navigate these institutional structures and reconcile the differences required patience, creativity, and flexibility to make them feel more relaxed, productive, and valued at work.

Participants experiences taught us that perimenopause deepened their identity as an experienced physiotherapist, a mentor, and an expert. Participants described the menopausal transition as a time for reflection; a time for questioning their relationship with their work; a time to both find their voice and become comfortable with this voice; and/or a time where they

prioritized their needs. Navigating time during the menopausal transition and their roles and responsibilities at work was significant to all participants. This finding reflected research by Jack et al (2019) where they concluded that time was significant for menopausal workers.

Participants reported new alliances developed during this time with colleagues, managers, the organization, and patients which aligns with research findings in Australia by Jack et al. (2019). New meanings emerged with allies as they supported each other and talked through the challenges of menopause in the workplace. While Jack et al (2019) found support through family members, in particular mothers, they were not specific about colleagues at work or their clients. My research adds interesting findings regarding the relationship of patients as influencers and allies in the perimenopause journey. Many physiotherapists identified patients as key allies in helping them normalize the menopausal experience at work.

This research provides a unique perspective of the dual roles for health professionals who work with menopausal patients and are undergoing their own personal experience of menopause. The literature explores the challenge for health professionals experiencing life as a patient means breaking down the protective barriers built around yourself to cope with your job. (Tuffrey-Wijne & Williams, 2015). In this research, we saw how many participants challenged the discourse of the patient/provider divide and welcomed the input and guidance from their patient throughout their menopausal journey.

This section of the findings brought forward the importance and meaning of the institutional structures for menopause including policies, regulations, and guidelines. Participants reported a lack of policies and supports within their workplaces that focus on aging, gender, health, and wellbeing. Participants reported that the institution has programs to guide retirement planning but there are no resources for managing the midlife years in the work environment.

Early indications suggest that integrating menopause support into health and wellbeing strategies helps mainstream menopause issues amongst staff (Verburgh et al., 2020). An alternative approach is to integrate aging and perimenopause into equity, diversity, and inclusion strategies to compliment institutional priorities for safe and inclusive work environments. Long-term assessment is required to consider whether it is more effective to integrate this work into existing policies as opposed to introducing a separate menopause policy or guideline (Targett & Beck, 2022).

In sum, engaging in spaces that did not seem to be designed for people as part of the menopausal transition, some participants came to understand menopause as a social creation. In turn, these experiences suggest how limited understandings or expectations of how menopause impacts individuals, and that these expectations dictate social practices and work environments as they relate to menopause.

A Moment of Reflection

In undertaking this research, I embarked on a personal learning journey about perimenopause and continue to reflect on what I discovered through this process. First, I was surprised by how fast it was to complete the recruitment process for this research. In three days, I was overwhelmed by the number of potential participants eager to share their stories. I had people from all walks of life who wanted to engage in this research and continue to reach out, asking for advice and support. Second, I was unprepared for the stories to be emotional and express their stresses, fears, sadness, and frustrations through the perimenopausal journey. The feeling of isolation and helplessness was profound for many participants. Third, through the stories, participants also demonstrated a solid commitment to improve the experience for the next

generation - this commitment to a better future that is inclusive and supportive to all individuals experiencing perimenopause.

8.3 Contributions

The study contributes to the scholarly dialogue on the relationship between perimenopause, health, and wellbeing in the workplace. Framed within feminist geography and using qualitative methods, the research examines the complex relationships between people and places (Andrews et al., 2014) to understand lived experiences of perimenopause in the workplace.

8.3.1 Theoretical Contributions

This research makes four theoretical contributions to the literature: age as a structure of power, application of feminist geography, health and place relationships, and a foundation for evidence-based interventions.

First, this research contributes theoretical insights into the experience of ageing in the workplace. By incorporating age as another identity of difference in feminist geography, this research provides insight into why researchers should recognize 'age' as another structure of power that organizes society and informs group identities (Enßle & Helbrecht, 2021). By considering the experiences of midlife, this research expands the scope of literature beyond the elderly to capture an under-researched stage of life (i.e., midlife).

Second, the application of feminist geography sheds light on how relations of power and inequality over the life course shape health and wellbeing as part of aging (Domosh, 2006, 2010). Examining life course experiences further exposes how gendered relations of power and inequalities experienced over time shaped experiences of wellbeing as part of aging and the menopausal transition (Finlay, 2021). This research emphasizes gender through other axes of power and diversity, such as race, sexuality, class, age, and place (Crenshaw, 1989; Mollett &

Faria, 2013; Nightingale, 2006). Feminist Geography was applied to both inform research design, data collection, and organization of the results.

Third, the research incorporates constructs of health geography, acknowledging that place-based experiences shape health and wellbeing (Gesler, 2002). The research guided a shift from biomedical preoccupations of perimenopause to the inclusion of social, cultural, and political components of place-based work environments (Brown, McLafferty, and Moon, 2011). The research responds to the gap in the literature that lacks consistent theoretical underpinning to understand the experiences of menopause across the life course (Verdonk et al., 2022; DeLyser & Shaw, 2013; Kleinman et al., 2013)

Finally, the physiotherapy profession lacks an explicit theoretical grounding, creating the misleading impression of an absence of tacit assumptions and biases (Gibson et al., 2010). In the absence of explicit theoretical underpinnings, identifying tacit assumptions and biases, particularly critique of them, is far more challenging and thereby occurs less frequently (Krieger, 2011). This research contributes by using social theory to enhance knowledge of the lived experience of perimenopausal physiotherapists. This work adds to emerging literature that incorporates theoretical framing to inform the design of evidence-based interventions for the physiotherapy profession.

8.3.2 Methodological Contributions

This research makes four contributions to the methodological literature. First, theory informs the research design, data collection and analysis. Through the narrative and document review in Chapter 2, I identified methodologies and methods that had yet to be used to explore the experience of perimenopause in the workforce. Few studies explore the experience of perimenopause in the workplace and the use of theoretical frameworks still needs to be improved

(Verdonk et al., 2022). This research contributes to this knowledge and methodological gap by aligning the theoretical perspective before examining the methodology and engaging with methods (Creswell & Poth, 2018; Gatrell & Elliott., 2015; Guba & Lincoln, 1994).

Second, this research used an exploratory research design (Stebbins, 2001) to understand a topic with the limited investigation and to recognize the lived experience(s) of participants (Polit & Beck, 2012). This design supports the detailed exploration of a phenomenon (Creswell & Poth, 2018) in which case study methodology was selected for this research (Yin, 2009). Given the lack of knowledge on menopause in the workplace, a case study contributed to how various environments (e.g., social, cultural, physical, political) inform health and wellbeing, why inequalities exist, and how these factors vary by population (Stake, 1995).

Third, the choice of methodology dictates the methods to be used in the research. Methods do not stand alone; they are tools used to answer research questions that align with a research question. For this research, qualitative interviews created space for participants to share their lived experience(s) and value their voices. This method was essential to understand the individual's subjective meaning of perimenopause in the workplace and allowed for socio-cultural, environmental, economic, and gendered factors to emerge. Iteratively analysed using reflexive thematic analysis (Braun & Clarke, 2006; 2021).

Fourth, COVID-19 required innovative data collection methods as the public health measures limited the ability to have in-person interviews. Traditionally, there is limited attention to remote data collection, but the pandemic raised attention to the long-term benefits (Keen et al., 2022). This research adds to our understanding of the potential benefits of using remote data collection (i.e., virtual interviews) in health geography research. This research benefited from increased geographic access to participants, flexibility in scheduling, no travel expenses, and all

interviews took place outside the workplace. However, some challenges were noted, including reading body language and potential distractions in the participant's environment. This research contributes to the emerging scholarly dialogue and interest in virtual qualitative research methodologies.

8.3.3 Substantive Contributions

This research offers several substantive contributions. First, the research contributes to the health geography literature, specifically understanding gendered health and wellbeing in place. This research gives a voice to Canadian physiotherapists as it documents the gendered dimensions of health and wellbeing in relation to the transition to menopause within the work environment. To date, limited research explores the gendered experience of transitioning into menopause in the workplace (Verdonk et al., 2022).

Second, the research contributes to the physiotherapy profession and community by bringing gender to the forefront of practice, professional development, and human resource strategies. As a profession, physiotherapy is criticized for neglecting gender in education, clinical practice, and research (Stenberg et al., 2021). In addition to the gender gap, there is a lack of research about aging, midlife and perimenopause in the workforce. This research contributes to understanding underlying systemic issues for physiotherapists within the profession. Finally, the physical and mental demands of the profession, the pressures on the Canadian healthcare environment, and the identified gap in the literature support the need to explore how physiotherapists currently experience and understand the menopausal transition within the workplace. This research contributes to the limited qualitative literature about the menopausal transition in the workplace and the experience(s) of physiotherapists.

Third, this research enhanced substantive knowledge by bringing new issues pertinent to menopause in the workplace – being well at work, the embodied experiences, and navigating supports – while enhancing knowledge on the meanings and experiences of aging in place. The focus on physiotherapy revealed how social differences structure aging in place. This work allowed for a reflective and critically informed base to derive explanations. Examining biomedical and sociocultural dimensions of health, wellbeing and aging in place demonstrated the importance of a feminist geography framework. This research enhanced our understanding of the role of the sociocultural environment in shaping health and wellbeing experiences and explains why examining these factors together is essential.

Finally, this work fills a critical knowledge gap in health, workplaces and menopause identified in the limited research (Verdonk et al., 2022). The research contributes evidence to understand the gaps, including the psychosocial aspects of the work environment, the role of social supports, differences across professions and sectors, and new analytical approaches to understanding perimenopause in the workplace. In addition, this research provides enhanced substantive knowledge by bringing forth new issues pertinent to menopause in the workplace – identity, workplace culture, impact for health professionals – while enhancing knowledge of the meanings and experiences of menopause in the workplace.

8.4 Implication for Education, Practice and Policy

The findings from this research have implications for education, practice, and policy.

8.4.1 Education

The findings have implications for physiotherapists and other health care providers during and after university education. There are gaps in how and when perimenopause and menopause are included in training and discussed by health care teams (Saperstein et al., 2018). Health care

teams should prepare to converse with their patients and team members about all phases of the reproductive cycle, including perimenopause. Having knowledge about menopause creates confidence to offer support to themselves, their team, and their patients (Saperstein et al., 2018).

Participants confirmed that their university training did not include information about menopause or perimenopause. The core curriculum of health care professionals should include training that normalizes perimenopause. Resources being developed, tested, and piloted would be a starting point for Canadian physiotherapy schools. An example is the International Menopause Society Professional Activity for Refresher Training (IMPART), with seven evidence-based modules accessible online. The training focuses on the menopause transition, including treatment options, made available for all health care professionals and trainees (Davis, 2018).

The recommendations for education highlight a need for a perimenopause education program for physiotherapists

1. Develop a core curriculum for entry-to-practice physiotherapists that normalizes perimenopause
2. Develop interprofessional learning opportunities for teams to learn about perimenopause within and across health disciplines
3. Create a menopause education program for physiotherapists as part of an accredited professional development opportunity

8.4.2 Practice

The research findings highlighted knowledge gaps specific to perimenopause within the physiotherapy profession. Perimenopause is considered a private health matter and not included in the institution's human resources or occupational health planning (UNISON, 2011). The findings illustrate the need to create awareness programs and review human resource data to

include employees' life stages. Three specific recommendations related to the practice setting from the findings and the literature (Verdonk et al., 2022) emerged through this research. These recommendations reflect a need to explore and support collaboration between health professionals and the physiotherapy profession.

1. Develop guidelines specific to the transition to menopause and work across all health professions
2. Develop strategies for flexible work environments to support perimenopausal employees
3. Develop a broad awareness-raising program about perimenopause at work for employers, employees, and patients
4. Revise human resource strategies and occupational health initiatives to capture health issues with a consideration of the life stages of employees

8.4.3 Policy

Specific workplace policies on menopausal health have recently become a focus in British and Australian institutions (Carter et al., 2021). However, research is identifying concerns about a targeted policy when there is limited knowledge of the impact of menopause in the workplace. A proposed alternative strategy from this research and an Australian team (Carter et al., 2021) recommends including menopause into pre-existing policies (Carter et al., 2021). This approach focuses on creating a safe and inclusive workplace aligning with the institution's commitment to equity, diversity, and inclusion (Todic et al., 2022).

8.5 Limitations and Future Research Directions

This research provides valuable insight into the gendered dimensions of health and wellbeing of Canadian physiotherapists' perimenopausal experience within the work environment. The findings reflected how physiotherapists describe being well at work, embody

the experience of perimenopause, and navigate supports within the workplace. Verdonk et al. (2022) concluded that menopause, health, and work require substantial attention to address the significant gap in research to support evidence-based strategies and policies. These findings add to the body of knowledge about the experience of perimenopause. However, despite multiple contributions, there are limitations that present numerous areas for future research.

Homogenous Sample

The recruitment method and inclusion criteria opened the possibility that the sample was biased toward perimenopausal individuals who had already medicalized their experiences, given that many of the participants were experiencing symptoms. In addition, participants in this study were relatively privileged in that they were predominantly white, middle-to-upper class, English-speaking, and highly educated and thus not representative of all working perimenopausal health professionals. Marginalized groups may have a different relationship with medicalization, medical power relations, and bodily expertise than white, middle-class, highly educated people (Brubaker, 2007). More research is necessary to explore the experience of perimenopause among diverse populations, including

a) people experiencing perimenopause who identify as transgender and non-binary,
b) diverse populations of working perimenopause people, including international settings, religion, culture, gender, social norms, family, community,
c) people from racialized communities,
d) people who experience early onset menopause,
e) further understanding of the dynamics among multiple co-occurring stressors is needed to provide individualized health care appropriately to midlife women, and

f) explore the experiences of family members (including children and partners) of perimenopausal people.

Expansion of Methods

The study was qualitative and based on self-reported data, susceptible to social desirability. In this case, participants could overstate or understate their experiences depending on expectations. This research used follow-up questions and subtle probes to enhance the experience and perception. Future research applying quantitative and qualitative data sources would expand knowledge in this area. In addition, future research using an integrated knowledge translation approach would make the findings translatable for programs, practices, and policy.

Impact of the Pandemic

This cross-sectional study collected data on a single time point and did not allow for the examination of potential changes over time. During this time, we were in the second year of a global pandemic, and public health measures were still in place across Canada. In addition, this group of health professionals had extra clinical duties because of the pandemic. Future research could explore the impact of public health measures on the perimenopausal experience at work, particularly for health care professionals.

Future Research Opportunities

Additional research that explores menopause and work across health professions would be beneficial. Currently, few studies explore menopause in the health professions (Bell et al., 2022; Prothero, Foster & Winterson, 2021; Geukes et al., 2020). The extension of this research would be to explore how other professions experience perimenopause, including how context influences perceptions, attitudes, and beliefs around menopause in the workplace.

8.6 Chapter Summary

In this chapter, I discussed the findings of this research. I have shown how participants explore being well at work, how they embody the experience of perimenopause, and navigate the supports. These findings were contextualized within the current literature on perimenopause to demonstrate how they contribute to the contemporary scholarly dialogue. The chapter identified the main contributions of the research and the limitations; it concluded with a discussion of the policy, practice and education implications of the findings and offered directions for future research.

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Appendix A: Ethical Clearance

Dear Susan Elliott and other members of the research team:

Your application has been reviewed by Delegated Reviewers. We are pleased to inform you the Initial application for 43019 Aging in the workplace: What is the experience of Canadian physiotherapists with the transition to menopause? has been given ethics clearance.

Note: Due to the current COVID-19 situation, research activities that require face-to-face/in-person interactions cannot be conducted until all procedures for research re-start (including safety plan approval) have been completed. For all in-person research protocols please review Frequently Asked Questions, processes and forms, and restart guidance. Direct any inquires to researchethics@uwaterloo.ca.

This research must be conducted in accordance with the most recent version of the application in the research ethics system and the most recent versions of all supporting materials.

Ethics clearance for this study is valid until Wednesday, April 6th 2022.

The research team is responsible for obtaining any additional institutional approvals that might be required to complete this Expedited study.

University of Waterloo Research Ethics Committees operate in compliance with the institution's guidelines for research with human participants, the Tri-Council Policy Statement for the Ethical Conduct for Research Involving Humans (TCPS, 2nd edition), Internalization Conference on Harmonization: Good Clinical Practice (ICH-GCP), the Ontario Personal Health Information Protection Act (PHIPA), and the applicable laws and regulations of the province of Ontario. Both Committees are registered with the U.S. Department of Health and Human Services under the Federal Wide Assurance, FWA00021410, and IRB registration number IRB00002419 (Human Research Ethics Committee) and IRB00007409 (Clinical Research Ethics Committee).

Renewal: Multi-year research must be renewed at least once every 12 months unless a more frequent review has been specified on the notification of ethics clearance. This is a requirement as outlined in Article 6.14 of the Tri-Council Policy Statement for the Ethical Conduct for Research Involving Humans (TCPS2, 2014). The annual renewal report/application must receive ethics clearance before Monday, March 14th 2022. Failure to receive ethics clearance for a study renewal will result in suspension of ethics clearance and the researchers must cease conducting the study. Research Finance will be notified ethics clearance is no longer valid.

Amendment: Changes to this study are to be submitted by initiating the amendment procedure in the research ethics system and may only be implemented once the proposed changes have received ethics clearance.

Adverse event: Events that adversely affect a study participant must be reported as soon as possible, but no later than 24 hours following the event, by contacting the Director, Research Ethics. Submission of an adverse event form is to follow the next business day.

Deviation: Unanticipated deviations from the approved study protocol or approved documentation or procedures are to be reported within 7 days of the occurrence using a protocol deviation form.

Incidental finding: Anticipated or unanticipated incidental findings are to be reported as soon as possible by contacting the Director, Research Ethics. Submission of the incidental findings formis to follow within 3 days of learning of the finding. Participants may not be contacted regarding incidental findings until after clearance has been received from a Research Ethics Committee to contact participants to disclose these findings.

Study closure: Report the end of this study by submitting a study closure report through the research ethics system.

Coordinated Reviews: If your application was reviewed in conjunction with Wilfrid Laurier University, Conestoga College, Western University or the Tri-Hospital Research Ethics Board, note the following: 1) Amendments must receive prior ethics clearance through both REBs before the changes are put in place, 2) PI must submit the required annual renewal report to both REBs and failure to complete the necessary annual reporting requirements may result in Research Finance being notified at both institutions, 3) In the event that there is an unanticipated event involving a participant that adversely affects them, the PI must report this to both REBs within 24 hours of the event taking place and any unanticipated or unintentional changes which may impact the research protocol shall be reported within seven days of the deviation to both REBs.

Initial application ethics clearance notification: Your clearance notification will be added to the record within 24 hours. Go to “Admin Notes and Files” in the research ethics system (right-hand side) to print a copy of the initial application ethics clearance notification.

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Best wishes for success with this study.

If you have any questions concerning this notification, please contact the Research Ethics Office or email researchethics@uwaterloo.ca.

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Appendix B: Information Letter and Consent Form

UNIVERSITY OF WATERLOO

RECRUITMENT OF STUDY PARTICIPANTS
Information Letter and Consent Form

Aging in the Workplace: What is the experience of Canadian physiotherapists with the transition to menopause?

This letter is an invitation to consider participating in a research study being conducted by Shawna O'Hearn as part of her PhD degree in the Department of Geography and Environmental Management at the University of Waterloo under the supervision of Dr. Susan Elliott. I would like to provide you with more information about this project and what your involvement would entail if you decide to take part.

There is a lack of knowledge that examines aging, specifically the perimenopause and menopause stages of life. The evidence is rarely provided by women themselves, in which they describe in their own words how they experience perimenopause, health, and wellbeing. Menopause is often described as a 'taboo' subject, particularly in the workplace. Many people are suffering in silence because they are afraid of the reaction they will receive from managers or colleagues if they mention their symptoms at work. This research will facilitate an improved understanding of the transition to menopause in the workplace. The aim is to assess how the transition to menopause affects the lives of physiotherapists by evaluating how they view their overall health and wellbeing, and how specific symptoms affect their work; and to gain insight into not only the individual factors (such as the workplace), but also the system-level factors (i.e. policies) that influence quality of life, healthcare, and employment/economic experiences.

Taking part in this research is voluntary and participating or not participating is entirely your choice. There will be no impact to you if you decide not to participate in this research. The information below tells you what is involved in participation, what you will be asked to do and about any benefit, risk, inconvenience, or discomfort that you might experience.

Participation will involve a virtual, remote interview of approximately 60-90 minutes. You may decline to answer any of the interview questions if you so wish. Further, you may decide to withdraw from this study at any time without any negative consequences by advising the researcher. With your permission, the interview will be audio recorded to facilitate collection of information, and later transcribed for analysis. Shortly after the interview has been completed, the researcher will send you a copy of the transcript to give you an opportunity to confirm the accuracy of our conversation and to add or clarify any points that you wish. All information you provide is considered completely confidential. Your name will not appear in any dissertation or report resulting from this study, however, with your permission anonymous quotations may be used. Only researchers associated with this project will have access to the transcripts.

The risk or harm to participants is expected to be minimal, no greater than those encountered in the everyday life of the participant. Depending on the nature of their workplace experiences, participants may encounter some emotional discomfort in the recounting of their experience. The questions being asked involve self-reflection on those experiences and a sharing of their feelings which could cause some psychological discomfort.

The interview will be conducted over Microsoft Teams. When information is transmitted over the internet privacy cannot be guaranteed. There is always a risk your responses may be intercepted by a third party (e.g., government agencies, hackers). University of Waterloo researchers will not collect or use internet protocol (IP) addresses or other information which could link your participation to your computer or electronic device without first informing you.

Your identity will be kept confidential. This data will be kept in a secured cabinet and password protected laptop and will be destroyed at least seven years after completion of the study. The findings will never reveal what individual people said and we will make all efforts to maintain confidentiality. There are no financial benefits for participating in the interview.

This study has been reviewed and received ethics clearance through a University of Waterloo Research Ethics Board (ORE #43019). If you have questions for the Board contact the Office of Research Ethics, at 1-519-888-4567 ext. 36005 or ore-ceo@uwaterloo.ca.

For all other questions or if you would like additional information to assist you in reaching a decision about participation, please contact me by email at sohearn@uwaterloo.ca. You can also contact my supervisor, Professor Susan Elliott at susan.elliott@uwaterloo.ca

I look forward to speaking with you and thank you in advance for your assistance in this project.

CONSENT FORM

I have read the information presented in the information letter about the study being conducted by Dr. Susan Elliott and Shawna O'Hearn with the Department of Geography and Environmental Management at the University of Waterloo. I have had the opportunity to ask any questions related to this study, to receive satisfactory answers to my questions, and any additional details I wanted.

I am aware that I have the option of allowing my interview to be audio recorded to ensure an accurate recording of my responses.

I am also aware that excerpts from the interview may be included in the dissertation and/or publications to come from this research, with the understanding that the quotations will be anonymous.

I was informed that I may withdraw my consent at any time without penalty by advising the researcher.

This study has been reviewed and received ethics clearance through a University of Waterloo Research Ethics Committee (ORE#43019). I understand that if I have any comments or

concerns resulting from my participation in this study, I may contact the Chief Ethics Officer, Office of Research Ethics, at 1-519-888-4567 ext. 36005 or ore-ceo@uwaterloo.ca.

For all other questions, I will contact Shawna O'Hearn at sohearn@uwaterloo.ca

With full knowledge of all foregoing, I agree, of my own free will, to participate in this study.

☐YES ☐NO

I agree to have my interview audio recorded.

☐YES ☐NO

I agree to the use of anonymous quotations in any dissertation or publication that comes of this research.

☐YES ☐NO

Information about the Interview Summary:

A summary of the results will be sent to each participant personally, unless otherwise indicated:

- ❑ Yes, I would like to receive a summary of the study's results.

  Please send them to me at this email address _____

- ❑ No, I do not want to receive a summary of the interview.

Appendix C: Request for Assistance with Recruitment of Study Participants

Dear XXX

I am writing to **request your assistance in recruitment for a research study** that I am conducting as part of my PhD in the Department of Geography and Environmental Management at the University of Waterloo, Ontario under the supervision of Dr. Susan Elliott.

The purpose of the study is to explore the experience of the transition to menopause within physiotherapy. This study will examine the relationship between employment conditions, work-related stressors and menopausal symptoms among perimenopausal and menopausal women. I would like to talk with physiotherapists to understand the nature and scale of perimenopause in the profession.

The information will be collected through interviews that the participant can opt into. Upon completion of the research, I will be preparing a dissertation and will share the findings with the research, physiotherapy and university communities through seminars, conferences, presentations, and journal articles.

I am requesting that you share the attached email and letter of information with your membership. If they are interested in participating and meet the eligibility requirements, they can contact Shawna O'Hearn to coordinate a remote interview.

Participation is completely voluntary. Each physiotherapist will make their own independent decision as to whether or not they would like to be involved. All participants will be informed and reminded of their rights to participate or withdraw at any time in the study. The attached letter provides more information about the research study, as well as informed consent.

To support the findings of this study, quotations and excerpts from the stories will be used labelled with pseudonyms to protect the identity of the participants. Names of participants and the name of the institution that they work(ed) for will not appear in the dissertation or any publications or presentations resulting from this study.

All paper field notes collected will be retained locked in my office and in a secure cabinet. All paper notes will be confidentially destroyed after three years. Further, all electronic data will be stored on a USB stick with no personal identifiers and destroyed after five years. Finally, only I will have access to these materials. There are no known or anticipated risks to participants in this study.

This study has been reviewed and received ethics clearance through a University of Waterloo Research Ethics Committee (REB # 43019).

The final decision about participation belongs to each individual physiotherapist.

If you have any questions regarding this study or would like additional information to assist you in reaching a decision about sharing the recruitment information with your members, please contact me by email sohearn@uwaterloo.ca.

I am requesting that you share the attached email and letter of information with your membership.

Yours sincerely,

Shawna O'Hearn, PhD Candidate
Department of Geography and Environmental Management
University of Waterloo

Proposed email to be shared with membership:

RE: What is the experience of the transition to menopause within physiotherapy?
[insert your preferred greeting and client name]

This email is being sent on behalf of the researchers.

Shawna O'Hearn is a PhD Candidate at the University of Waterloo who is conducting research under the supervision of Dr Susan Elliott. She is inviting physiotherapists who are registered as a licensed physiotherapist in Canada; employed in Canada as a physiotherapist; and are between the ages of 40 and 60 years who have or are currently experiencing perimenopause or the transition from reproductive years to menopause.

Your participation in this research is completely voluntary. Participation will include a virtual, remote interview of approximately 60-90 minutes.

The research is investigating the experience of the transition to menopause for physiotherapists in their work setting. This study will examine the relationship between employment conditions, work-related stressors and menopausal symptoms among perimenopausal and menopausal women.

If you would like to participate in this research study and/or would like more information, please contact Shawna O'Hearn at sohearn@uwaterloo.ca. An information letter with more details is also attached.

This study has been reviewed and received ethics clearance through a University of Waterloo Research Ethics Committee

If you know a physiotherapist who has experience with perimenopause, please forward them this email.

Appendix D: In Depth Interview Guide

Hello. My name is Shawna O'Hearn and this research is being conducted as part of my Ph.D. degree in the Department of Geography and Environmental Management at the University of Waterloo under the supervision of Dr. Susan Elliott. Let me provide you with more information about this project and what your involvement would entail if you decided to participate.

This research will facilitate an improved understanding of the transition to menopause in the workplace. The aim is to assess how the transition to menopause affects the lives of physiotherapists by evaluating how they view their overall health and wellbeing, and how specific symptoms affect their work; and to gain insight into not only the individual factors (such as the workplace), but also the system-level factors (i.e., policies) that influence quality of life, healthcare, and employment/economic experiences.

Before proceeding, I want to review the inclusion criteria.

Inclusion Criteria	**Yes**	**No**
Are you registered as a licensed physiotherapist in Canada?		
Are you employed in Canada as a physiotherapist?		
Are you experiencing perimenopause and between the ages of 40 and 60 years? Or are have you experienced the transition from the reproductive years through to menopause and beyond?		

Does not meet Inclusion Criteria
Thank you. Unfortunately, you do not meet the inclusion criteria for this research. I want to sincerely thank you for your interest in this research.

Meets the Inclusion Criteria
Thank you. You have met the inclusion criteria for this research. Let's continue.

VERBAL CONSENT

Taking part in this research is voluntary and participating or not participating is entirely your choice. There will be no impact to you if you decide not to participate in this research. Your participation will be for about 60-90 minutes. You may decline to answer any of the interview questions if you so wish. You may decide to withdraw from this study at any time without any negative consequences by advising me.

With your permission, the interview will be audio recorded to facilitate collection of information, and later transcribed for analysis.

Do you provide permission for your interview to be audio recorded? Yes No

Your identity will be confidential. Your name will not appear in any dissertation or report resulting from this study, however, with your permission anonymous quotations may be used. Only researchers associated with this project will have access to the transcripts.

This data will be kept in a secured cabinet and password protected laptop and will be kept for at least five years after completion of the study.

With full knowledge of all foregoing, I agree, of my own free will, to participate in this study.

☐YES ☐NO

I agree to the use of anonymous quotations in any dissertation or publication that comes of this research.

☐YES ☐NO

I will email you a copy of the transcript to give you an opportunity to confirm the accuracy of our conversation and to add or clarify any points that you wish.

- ❑ Yes, I would like to receive a summary of the study's results.

  Please send them to me at this email address _____

- ❑ No, I do not want to receive a summary of the interview.

Theme: Context

1) Can you tell me a little bit about yourself?
   Probe
   - Where did you train to be a physiotherapist?
   - Where are you from?
   - How long have you been a physiotherapist? What roles have you had as a physiotherapist?

Theme: Health and Wellbeing

2) We talk a lot about "health and wellbeing". What do these terms mean to you?

3) How would you translate "health and wellbeing" to your working life?

4) What does it mean to be "well" at work?

Theme: Menopause Transition

5) What does the menopause transition mean to you?
   Probe: What are your feelings about menopause?

6) Do you consider yourself to be in menopause?
   Probe: Do you know what phase of menopause you are in?
   Probe: Was your menopause spontaneous? Surgical? Or due to chemotherapy or radiation therapy?

7) How did you notice that you are in menopause (or menopause transition)?

8) Could you tell me about your menopausal experiences?

9) What does it mean to you to "be menopausal"?

10) What are the differences in your health/ wellbeing/ daily life before and after menopause?
   Probe
   - Is there any change in your life related to menopause?
   - Is there any relation between menopause and general health? Does menopause affect your general health?

11) Do you have any symptoms? If yes, which symptoms?

12) How do (did) you manage the symptoms?

Theme: Aging in the Workplace

13) Does your workplace have policies to support your health and wellbeing? If so, can you tell me about them.
   Probe: Are there policies that focus on aging in the workplace? Do the policies identify unique needs based on sex and gender in the workplace?

14) Does menopause affect your work? If so, how?

15) Can you describe how your life (and work) is better because of going through the menopausal experience?

16) Can you describe some instances where the menopausal experience has adversely affected your daily life events or activities at work?

17) What could employers do to help people experiencing menopausal symptoms at work?

18) To what extent is the menopause transition a problem for physiotherapists?

Conclusion

19) Is there something you want to add to this interview?

20) From all that you told me today, what is the most important to you?

Other Question

21) If you know of another physiotherapist who meets the study criteria please feel free to ask them to get in touch with me.

General Probes

- Would you give me an example?
- Can you elaborate on that idea?
- Would you explain that further?
- I'm not sure I understand what you're saying.
- Is there anything else?

Appendix E: Sample of Initial Coding

Category	Main Code	Sub Code
1. Physical experience of menopause	1.1 My body is changing	1.1.1 My body is changing 1.1.2 My body is changing permanently 1.1.3 My periods are changing 1.1.4 Start to notice hot flashes/night sweats 1.1.5 Some activities are easier or unchanged
	1.2 My body is unpredictable	1.2.1 Body becoming unpredictable 1.2.2 Body becoming uncontrollable 1.2.3 Not knowing what will happen 1.2.4 Not knowing when it will start 1.2.5 Not knowing when it will stop
	1.3 Feeling diminished by my body	1.3.1 Feeling undermined by my body changing 1.3.2 Menopause is affecting my memory 1.3.3 I think I am not coping 1.3.4 Affecting sleep/tired 1.3.5 Affecting concentration 1.3.6 Body requires more care/attention 1.3.7 Feeling physical discomfort
	1.4 Not recognizing any changes	1.4.1 Untroubled by symptoms 1.4.2 Menopause is hidden to me 1.4.3 Feeling relief and freedom 1.4.4 Getting off lightly
2. Managing Menopause	2.1 Managing my changes	2.1.1 Just getting on with it 2.1.2 Choosing not to focus on my menopause 2.1.3 Looking after my body 2.1.4 Treating symptoms 2.1.5 Looking for patterns in my symptoms 2.1.6 Finding what works by trial and error 2.1.7 Not treating menopause symptoms because I can cope 2.1.8 Changing lifestyle 2.1.9 Viewing the body as fixable
	2.2 Asking for support to manage the changes	2.2.1 Seeking medical advice 2.2.2 Resisting medicalization 2.2.3 Treating symptoms 2.2.4 Trying alternative remedies 2.2.5 Taking HRT 2.2.5.1 Feeling uncertain about taking HRT 2.2.5.2 Feeling confident about taking HRT 2.2.5.3 Feeling stigma about using HRT 2.2.6 Becoming informed 2.2.7 Information and support not available 2.2.8 Not knowing enough about my body 2.2.9 Finding out about treatments from other women 2.2.10 Comparing my menopause with other women 2.2.11 Using mother as a benchmark

	2.3 Exploring beyond the physical experience	2.3.1 Being more emotional 2.3.2 Being surprised by my feelings 2.3.3 Understanding emotion in terms of hormones 2.3.4 Getting angry 2.3.5 Angry that menopause is hidden/ignored 2.3.6 Getting anxious 2.3.7 Loss of confidence 2.3.8 Becoming more confident 2.3.9 Controlling my emotions 2.3.10 Expressing my emotions
	2.4 Transformative Experience	2.4.1 Restructure identity 2.4.2 Finding a new voice 2.4.3 Recognized for a person with experience and expertise 2.4.4 Natural part of life 2.4.5 Sense of liberation
3.0 Keeping it Hidden	3.1 Taboo	3.1.1 Stigma 3.1.2 Not talking about gendered bodies 3.1.3 Being in denial 3.1.4 Resisting menopause beforehand 3.1.5 Resisting thoughts about aging and health 3.1.6 Not knowing about menopause 3.1.7 Not knowing about other people's experience 3.1.8 Choosing to ignore my experience
	3.2 Keeping it private	3.2.1 Not disclosing menopause 3.2.2 Not wanting supervisor/boss to see I am menopausal 3.2.3 Not wanting clients to see I am menopausal 3.2.4 Avoid attention to my age 3.2.5 More open than our mothers and grandmothers 3.2.6 Not talking to mother about menopause 3.2.7 Not aware of partners knowledge of menopause 3.2.8 Talk to my children about menopause 3.2.9 Use humour to communicate 3.2.10 Talk to peers about menopause
	3.3 Expectations	3.3.1 Expecting menopause to be bad 3.3.2 Not having expectations 3.3.3 Expect not to be understood by people who haven't experienced menopause 3.3.4 Making sense of what is happening to me 3.3.5 Applying scientific/medical thinking to my experience 3.3.6 Thinking of menopause as developmental 3.3.7 Trying to understand how menopause interacts with other life changes and stages
	4.1 Resisting an old narrative	4.1.1 Resisting narratives of menopausal women – just another frumpy old woman 4.1.2 Holding dismissive/derogatory attitude to older/menopausal women

4.0 Not the End of Life		4.1.3 Expecting to be viewed negatively if seen as menopausal 4.1.4 Men holding dismissive/derogatory views of older women 4.1.5 Younger team members holding dismissive/derogatory views of older women
	4.2 Changing Identity	4.2.1 Dreading the impact of menopause on my appearance 4.2.2 Beginning to look older than I feel inside 4.2.3 Changes in my appearance impacting how I feel about myself 4.2.4 Thinking of myself becoming less attractive/looking older 4.2.5 Thinking of myself as becoming less feminine/desirable 4.2.6 Wondering if my partner will value me less 4.2.7 Expecting to be treated dismissively if I look older 4.2.8 Criticizing myself for caring about my looks 4.2.9 Being treated differently in the workplace as a menopausal woman 4.2.10 Holding onto my identity
	4.3 Fear of this new phase of life	4.3.1 Fear of becoming invisible 4.3.2 Fear of being judged as someone on their way out 4.3.3 Anticipating being an older woman will affect my roles in the work force 4.3.4 Behaving as though I will be discriminated against 4.3.5 Avoid drawing attention to my age 4.3.6 Feeling less confident to challenge work culture about menopause 4.3.7 Age being viewed differently in men 4.3.8 Acknowledge ageism can apply to men too
	4.4 Reflecting on life course	4.4.1 Thinking it is more than the physical change 4.4.2 Looking back/feeling nostalgia for youth 4.4.3 Acknowledging loss of maternal role 4.4.4 Re-evaluating lifestyle 4.4.5 Evaluating my achievements
	4.5 Remaining Valuable	4.5.1 Thinking about the future 4.5.2 Wanting to grow/contribute 4.5.3 Not letting menopause stop life 4.5.4 Claiming status as a wise woman 4.5.5 Becoming more confident 4.5.6 Planning for the next life stage 4.5.7 Planning for retirement
	4.6 Reflecting on my Mortality	4.6.1 Being reminded of mortality 4.6.2 Thinking that time is running out 4.6.3 Accepting I cannot turn back time 4.6.4 Menopause making me think like a feminist/woman 4.6.5 Comparing menopause to pregnancy/puberty 4.6.6 Fertility not being important in how I think about myself

		4.6.7 Not having words to use for the life stage I'm entering
5.0 Experience of working during the Transition	5.1 Type of work	5.1.1 Clinical 5.1.2 Management 5.1.3 Academia
	5.2 Timing of Work	5.2.1 Full time 5.2.2 Moving to flex time 5.2.3 Part-time/job sharing 5.2.4 Availability of leaves of absence
	5.3 Location of Work	5.3.1 Clinical 5.3.2 Work from home 5.3.3 Public 5.3.4 Private 5.3.5 Urban 5.3.6 Rural
	5.4 Renegotiating Responsibilities	5.4.1 Role of front-line health professional 5.4.2 Impact of health system demands on career 5.4.3 Changing roles for a physio in the health system 5.4.4 Impact of pandemic on responsibilities 5.4.5 Reassess roles
	5.5 Structural factors	5.5.1 Intense physical demands 5.5.2 Team support 5.5.3 Work independently 5.5.4 Support from patients 5.5.5 No flexibility in work hours 5.5.6 Flexibility of hours
	5.6 Career trajectory	5.6.1 Precarious contract work 5.6.2 Seniority with higher employment security 5.6.3 Ability to seek early retirement 5.6.4 Post retirement
	5.7 Social Networks at Work	5.7.1 Quality of personal relationships 5.7.2 Workplace culture 5.7.3 Relationship with supervisor 5.7.4 Relationship with patients
	5.8 Temporal Connections	5.8.1 Body is out of rhythm with the organization's temporal expectations 5.8.2 Disorientated and questioning identity in workplace 5.8.3 Changing relations 5.8.4 Challenging the system of silence in the organization
	5.9 Exploring place through the transition	5.9.1 New bodily experiences does not correlate with the work place (feel exposed/visible) 5.9.2 Other factors (age, gender, health) impacting relationship with work 5.9.3 Negotiate symptoms across cultural dynamics of workplace
	6.1 Adaptive occupational responses	6.1.1 Immediate action to control current situation 6.1.2 Taking immediate action to control professional errors 6.1.3 Time management

6.0 Coping strategies in work environments as part of the transition		6.1.4 Doing less/pacing self 6.1.5 Relying more on informal supports
	6.2 Seek Help	6.2.1 Ask for help from supervisor 6.2.2 Take support from coworkers 6.2.3 Ask advice from patients 6.2.4 Supportive social networks 6.2.5 Understanding institutional supports (i.e. policies)
	6.3 Focus on well being	6.3.1 Spend time with spouse/partner/family 6.3.2 Maintain balance between professional and personal lives 6.3.3 Maintain sense of humor 6.3.4 Engage in physical activities 6.3.5 Maintain self-awareness
	6.4 Disengage from workplace and space	6.4.1 Avoidance 6.4.2 Increased absenteeism 6.4.3 Retirement from paid employment 6.4.4 Re-engage in other spheres of life 6.4.5 Leave institution 6.4.6 Switch Tasks 6.4.7 Loss of meaningful life space 6.4.8 Intention to leave workplace 6.4.9 Intention to leave labour force
7.0 Facilitate active engagement in work environments	7.1 Social Factors	7.1.1 Supportive colleagues 7.1.2 Supportive supervisors 7.1.3 Sense of community
	7.2 Economic Factors	7.2.1 Privilege of employment 7.2.2 Privilege of benefits 7.2.3 Financial implications
	7.3 Structural Factors	7.3.1 Inclusive policies in the workplace 7.3.2 Education in the workplace – particularly for managers 7.3.3 Engage male colleagues in dialogue 7.3.4 Engage management and leadership 7.3.5 Education in professional programs 7.3.6 Attention to workplace environment (i.e. temperature and ventilation)
	7.4 Cultural Factors	7.4.1 Change language of transition to empower women 7.4.2 Menstrual health education in schools, work and university 7.4.3 Illness perceived as weakness 7.4.4 Hierarchy of healthcare professionals 7.4.5 Ageism and Sexism 7.4.6 Aging is viewed as weakness
8.0 Exploring Health and Wellbeing	8.1 Defining health	8.1.1 Physical Health 8.1.2 Mental Health 8.1.3 Body Functioning 8.1.4 Nutrition 8.1.5 Resilience
	8.2 Defining wellbeing	8.2.1 Mental Health 8.2.2 Spiritual

		8.2.3 Happiness 8.2.4 Wellness
	8.3 Being well at work	8.3.1 Support patients 8.3.2 Respect 8.3.3 Valued 8.3.4 Celebrate accomplishments 8.3.5 Work life balance 8.3.6 Supportive team 8.3.7 Accomplishing work demands
	8.4 Perceptions of personal health	8.4.1 Healthy lifestyle is important 8.4.2 Healthy until 50
	8.5 Redefining women's health	8.5.1 Not only about women's health 8.5.2 Inclusion of trans people into the healthcare system 8.5.3 Rebranding of health care to be inclusive of all 8.5.4 Diversity should include aging