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**Menopause in Context:  
A Constructivist/interpretive Perspective  
on the Attitudes, Perceptions, Expectations and Experiences  
Among Women in New Zealand**

**A thesis presented in fulfilment of the requirement  
for the degree of Doctor of Philosophy  
in Social Anthropology  
at Massey University**

**Annette Noble Beasley**

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## **Errata**

p16 line 5 **for** lense **read** lens

p103 line 11 **for** fledging **read** fledgling

p120 line 25 **for** trails **read** trials

p228 line 1 **for** syml **read** symptom control

p272 line 12 **for** tired **read** tried

p355 line 19 **for** practitioner's **read** practitioners

pp370-372 (Appendix 4) are in the wrong order and should be read as follows: p372,  
p371 and then p370

## ABSTRACT

This study examines the attitudes, perceptions, expectations and experience of menopause among women in New Zealand. It is based on focus groups and in-depth interviews with women aged thirty and above in the Feilding-Manawatu district and on narratives provided by respondents residing throughout the country. Additional information was collected from general practitioners, and readily accessible menopause educational programmes and material were also examined. The aim was to explore the social construction and individual experience of menopause with particular attention to the relation between the deficiency disease model and common sense knowledge about this life event. A constructivist/interpretive theoretical perspective was employed that recognises the socially constructed nature of menopause experience and accepts normative definitions of the feminine as crucial to social perception and individual experience.

Contrary to the medical view of menopause as a disease of hormone deficiency, the women maintained a common sense perception of this event as a normal, natural life-stage. Overall, their knowledge of physiological processes was limited and reflected the impact of medicalisation. Three central meanings associated with menopause were identified as mid-life and ageing, loss of fertility and health risk. Control of the menopausal body (the body politic) emerged as the central aspect of experience across the four age groups of women who defined themselves as 'in' or 'through' menopause. Against a tradition of taboo surrounding matters of female reproductive functioning and sexuality, the mechanisms or strategies of control have changed over time. There has been a shift from a strategy of stoicism (among those aged sixty and above) to the use of 'natural' strategies and hormone replacement therapy (commonly adopted by women in their fifties and forties). Each of these strategies was a response to common sense understanding of this event and accompanying social sanctions. Two broad conclusions were reached. First, that the deficiency disease model presents a linear, causal explanation of menopause which fails to recognise medical knowledge as part of the broader socio-cultural and historical processes which give meaning to this event. Second, that as women's experience of menopause occurs at the interface of socio-cultural, historical and physiological processes, the meanings of menopause are fluid and change over time.

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Approval for the research undertaken in this study was obtained from the Massey University Human Research Ethics Committee.

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## Introduction

As an event which affects all mid-life women, menopause is surrounded by popular stereotypes reflecting common sense understandings of this life-stage. In the course of data collection for this study I came across many such views but two in particular come to mind. The first was encountered when I called into the office of the Feilding Community Learning Centre to book a room for a series of focus group meetings. Two middle-aged women in the office expressed their interest in the study and pointed to a creased, fading cartoon/poster on the wall which conveyed their rejection of negative stereotypes. This poster (see Figure 0.1), depicting three elderly and rather formidable looking women clad in black, included a caption which read ‘Real women don’t have hot flushes! They have power surges!’ The women’s stance, their facial expressions and the caption convey a sense of matriarchal ‘political’ power and menace that is not to be ignored or taken lightly. The second view, which appeared to represent a reaction to the first, was encountered several months later when I travelled to a farm in the Feilding-Manawatu area to conduct an in-depth interview. The participant handed me a cartoon (see Figure 0.1) that she had cut out of a recent issue of the *New Zealand Farmer* (30 May 1996:8). It depicted a dairy cow ‘escaping’ down a broken stock race, leaving behind a farmer flat on his back, arms and legs splayed, tangled among shattered railings. Two other dairy cows look on while a third comments ‘...That’s why it’s called a power surge instead of a hot flush!’ This cartoon, perhaps unwittingly, affirms a negative stereotype that associates menopause with erratic, unpredictable behaviour that disrupts the normal, orderly pattern of everyday life.

These cartoon representations of menopause are, of course, only two examples among a plethora of predominantly negative stereotypical perceptions which surround this event and feed into common sense views. Underpinning a view of menopause as a normal life-stage, for example, are essentialist notions of the feminine which both confirm and sustain stereotypical perceptions of this event as characterised by features such as mood swings, irritability, forgetfulness, erratic or eccentric behaviour, mental illness and the loss of sexual attractiveness with ageing, in addition to the experience of



They Have POWER Surges!



"...That's why it's called a power surge instead of a hot flush!"

Figure 0.1: Two cartoons concerning menopause

hot flushes. Not surprisingly, the stereotypical menopausal woman is frequently the butt of jokes, social disdain and even prejudice. However, as the cartoon provided by the two office staff at the Feilding Community Learning Centre suggests, there is also resistance to negative stereotypes. The recasting of a 'hot flush' as a 'power surge' represents one example and another is the notion of the post-menopausal period as a time of renewed energy and vigour when the 'normal' woman will 'climb mountains' or embark on new ventures and tackle new challenges.

In addition to the abundance of stereotypical views, public discussion of menopause has traditionally been surrounded by social taboo. As a result the experience has essentially remained private and women have been restricted in their development of and access to shared, experience-generated common sense knowledge. A search of *The New Zealand Woman's Weekly* for the period 1942 to 1962, for example, yielded only two direct references to 'the menopause', both of which were little more than asides in a series of articles titled 'The Secrets of Staying Young' (see Solon, 1957a:7; Solon, 1957b:10). More recently, however, there has been a dramatic increase in public discussion and attention to the subject. It is now not uncommon to open a newspaper or magazine and discover a feature article on menopause. Unfortunately, much of this publicity is informed by and perpetuates the same old (predominantly negative) stereotypical views of this event.

In an article in the national *Sunday Star-Times*, Coney (1994:D2) pointed out that: 'Now its a hot topic on the women's health scene...menopause [has been] described as 'one of the major health issues of our time''. She then proceeded to identify current perspectives on menopause, the physical changes which occur at this time, the 'classic' symptoms, and both long- and short-term management strategies that have become a contentious issue in relation to the 'pros' and 'cons' of Hormone Replacement Therapy. The issue of management strategies was nevertheless clear cut for one prominent New Zealander. In an article on the issues faced by baby boomers as they turned fifty, Sharon Crosbie, Chief Executive of Public Radio, said (Roger, 1996:57):

Women have to come to terms with the fact that 50 is mid-life in the hormonal sense, and you do tend to reflect a lot on that...But with hormone-replacement therapy, at least one reflects on one's life in a degree of tranquillity which one might not otherwise attain.

More recently, Wellington's *Evening Post* newspaper presented a two page feature on women and longevity. The article began by posing the question (Dekker, 1997:19):

Hot flushes, insomnia, depression - is it all down-hill for women in middle age? Not anymore. Even identifying a woman of middle age is tricky....Yet the myth of middle age bringing a spiralling, inevitable reduction in the quality of women's lives persists.

Referring to a recent British study which found that 'depression decreased in women after menopause [and] life gets better, not worse, for women past 55', Dekker noted that despite the absence of 'comparable research in New Zealand...there is no reason to believe that New Zealand women feel differently'.

Another development in media attention has been the emergence of the menopause 'infomercial'. For example, *The Dominion* (26 November 1998:20) carried the headline 'Check-ups urged - The Wellington Menopause Clinic is stressing health checks for older women'.<sup>1</sup> This feature, which included a photograph of the clinic's two women doctors who were 'part of the...team helping to prevent heart disease and osteoporosis', emphasised the clinic's aim to 'empower women to optimise personal health from mid-life on'. Common health problems and risks associated with menopause as a condition of hormonal decline were also detailed. Similarly, an advertisement in a free quarterly magazine produced for the customers of a national supermarket chain, described menopause as (Foodtown, 1997:3):

...a time of intense readjustment and re-evaluation for many women [when] your body is coping with see-sawing hormone levels, and accompanying symptoms of tiredness and stress.

The advertisement promoted the dietary supplement 'Menopace' as a product that took 'the traditional approach to supporting menopause naturally and gently, and which was specifically formulated to help ease menopausal symptoms'. Obviously the menopause market was large, growing and open to competing claims, products and services.

While the articles and 'infomercials' cited above breach the traditional silence surrounding menopause and open it up for public discussion, they nevertheless emphasise the association between menopause, ageing and health problems. In so

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<sup>1</sup> *The Dominion* is Wellington's daily morning newspaper.

doing they advocate the need for women to become better informed and to actively manage this life transition. But as Coney (1994:D2) noted:

Talking about menopause is a double-edged sword for while it helps to be informed, dwelling on it may transform an event most women cope with readily into a source of worry.

Coney's (1994) comment signals two other relatively recent developments; namely, the appearance of self-help manuals and the debate surrounding the management of menopause with Hormone Replacement Therapy (HRT). Prior to the appearance of the two slim New Zealand produced self-help manuals by MacKenzie (1984) and Potter (1991), women seeking readily accessible information on mid-life and menopause, appropriate lifestyle and management strategies, were forced to rely on North American and British produced material.<sup>2</sup> Although useful, the overseas publications did not specifically address the situation or needs of New Zealand women who, from the late 1970s, have been increasingly exposed to publicity on the identification of menopause as a hormone deficiency disease and its potential for management with HRT. The two local self-help manuals were published in response to this need and aimed to assist women in making informed choices on those management strategies they considered most appropriate to their personal circumstances.

Although there appear to be no national figures available, in the early 1990s it was thought that 'New Zealand women [had] been using hormone replacement therapy at about the same rate as women in Australia and the United Kingdom' (National Advisory Committee on Core Health and Disability Support Services, 1993a). Deeply concerned over the medicalisation of menopause and its potential for commodification, Coney (1993) produced *The Menopause Industry: A Guide to Medicine's 'Discovery' of the Mid-life Woman*. Published prior to a report on HRT by The National Advisory Committee on Core Health and Disability Support Services (1993b), Coney's book proved to be particularly significant in the debate on HRT use and the perception of menopause and its management in New Zealand in the 1990s. However, while Coney drew attention to inadequacies in research surrounding the risks and benefits of HRT and alerted women to the politics of HRT marketing, her strident opposition to this

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<sup>2</sup> See Chapter 1 for further discussion of the New Zealand self-help manuals.

treatment was in some respects no less coercive than the medicalisation process of which she was so critical.<sup>3</sup>

## **PERSONAL MOTIVATION AND INTEREST**

As a fifth-generation New Zealander born just after the end of the Second World War, I grew up like most young women of that time with the expectation of marriage and motherhood. In 1969 when I gave birth to the first of my five children there was an increasing trend in this country towards natural childbirth and the promotion of breastfeeding. As a full-time mother I had the opportunity to become involved in relevant community groups where such matters were commonly discussed. During the 1970s and 1980s, while an active La Leche League member and Leader, I was exposed to a wealth of newly published information on the process of birth and birthing choices, related female reproductive functioning and breastfeeding.<sup>4</sup> As a result, I felt well informed on menstruation, childbirth and breastfeeding. However, I could not say that I felt the same way as I approached menopause.

Two factors then underlying my limited personal knowledge on menopause stand out. First, the reaction of my maternal relatives whenever I raised the subject. In response to my queries my mother's standard reply was 'Well I never knew I had it. It was like falling off a log! My periods just stopped when I was fifty'. My aunt, twelve years older than my mother, gave a similar response but her periods stopped at age thirty-nine. She told me how after an interval of nearly three months she mentioned the fact that she had not menstruated to my grandmother, who said 'Oh! You are pregnant!' However, before she could make an appointment to see the doctor she menstruated for the last time.

The second factor concerned my own perception that menopause was something which happened to older women and the belief that I was 'too young' for this life-stage. I therefore felt little interest in the topic until I started experiencing menstrual irregularities in my late forties. On seeking appropriate information, I was surprised to

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<sup>3</sup> See Chapter 8 for an elaboration of this point.

<sup>4</sup> La Leche League is an international, mother-to-mother organisation for the promotion and support of breastfeeding.

discover that New Zealand-orientated material - that is, material based on the experience of New Zealand women and/or produced specifically for New Zealand readers - was very limited. As an alternative, I was recommended *The Silent Passage* (Sheehy, 1993). Although written for and about North American women, a number of Sheehy's observations struck me as familiar. For example, her identification of both a lack of readily available information on menopause and the social taboo surrounding discussion of the subject (Sheehy, 1993:3). Most striking of all, however, was her statement that (Sheehy, 1993:26):

Very rarely had any of the women I interviewed learned much about menopause from their own mothers. If they reported any mother-daughter conversation on the subject at all, the mother's answers tended to be brief and evasive: 'There was nothing to it'; 'My periods just stopped'; or 'I don't remember much about menopause'.

In fact, Sheehy's reference to mother-daughter conversations on menopause was the initial catalyst for this study. It stimulated my curiosity as to why mothers (and older women) would not talk about this event and why it was so difficult to access experiential information. I already knew that my mother was reluctant and embarrassed to talk about other aspects of female reproductive functioning, but was menopause really a non-event in her life and that of other women? I certainly remembered my mother having problems with flooding and severe migraines throughout her forties. Were these 'problems' part of menopause? And if so, why did she not make the connection? Could I expect a similar experience?

Not only did Sheehy's comments stimulate a lot of questions about women's and society's attitudes towards menopause but I happened on them at a time when I was seeking a thesis topic. Having carried out an earlier study on women's breastfeeding experience (Beasley, 1996), I was already interested in issues relating to women's reproductive health and so menopause seemed a logical extension of this earlier work. My commitment to the topic was confirmed when, as part of the preliminary fieldwork, I attended a menopause workshop in Auckland. The presenter (Sandra Coney) pointed to the lack of local knowledge on women's experience of menopause and the fact that no-one seemed to be 'asking women themselves' about their views on this life-stage, about the nature of their experiences and the management of symptoms.

Clearly my curiosity regarding menopause identifies me as a 'product' of a particular time, as part of a generation of women who have lived through and in many respects benefited from a period of marked social change. In contrast with our mothers and women from earlier generations who knew little about their reproductive functioning, the members of my own generation (influenced by the women's movement of the 1960s and 1970s) assert that it is their right to have the knowledge and to remain in control of their reproductive functioning. But my curiosity was also a reflection of my interests in the areas of women's health, medical anthropology and the cultural construction of scientific and medical knowledge.

The point to note here, of course, is that as a post-war baby boomer cum 'meno-boomer',<sup>5</sup> my social location as a researcher and social anthropologist brings a particular perspective to this thesis and so identifies it as part of the social construction of knowledge on menopause. Abrahams (1986:49) points out that:

...experience underscores the ongoingness of life and the open character of ongoing actions, yet it also encourages us to see actions as units of behaviour that can be separated from the rest of action and talked about later on.

Because experience connects the present with the past and informs the future, it encourages the examination and interpretation of current activities in terms of meanings which are relevant to and reflect our own unique situation. As Abrahams (1986:50) puts it, 'we recognize ourselves as members of a generation, a network, a community'. In this way experience is always contestable (and therefore political) as it involves and requires both immediate interpretation and the need for reflection and retrospective interpretation. The point being made, of course, is that my collection and interpretation of data for this thesis is inevitably shaped and constrained by my own particular 'need to know' and explain the experience of menopause among New Zealand women.

## **PREVIOUS NEW ZEALAND RESEARCH**

A search of the New Zealand academic literature for research on menopause revealed that no nationwide study had been undertaken and the existence of very few sub-

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<sup>5</sup> The term 'meno-boomer' was coined by Barbre (1993) in reference to the ageing female post-war baby boomers.

national or 'local' studies. Other than biomedical research on specific physiological or biochemical aspects of menopause, and Coney's (1993) landmark study *The Menopause Industry*, only two substantial social science studies which focused exclusively on menopause were located. Both were Masters theses. Hamilton (1990) conducted a survey on the attitudes and perceptions of menopause among sixty-four Canterbury<sup>6</sup> women, while Duncan (1995) employed focus groups and in-depth interviews to examine the attitudes and experiences of six urban, five lesbian and ten rural women from the Wellington region. Another study, conducted by the Society for Research on Women (1988), surveyed four hundred and forty-five Christchurch women about their health and experiences at mid-life. Although not specifically on menopause, this study did address a number of related issues such as the women's attitudes, expectations and knowledge, and possible links between mid-life stresses and the incidence of menopausal symptoms.<sup>7</sup>

In addition to revealing the dearth of previous New Zealand research, the initial literature review also highlighted ambiguities associated with the definition of menopause. Strictly speaking the term refers to a woman's last menses, an event which can only be identified through hindsight. However, as Kaufert and Gilbert (1986:8) point out:

...this particular definition has proved too narrow and, even in the medical literature, 'menopause' tends to be used more broadly as the label for the period of time preceding and following upon the last menstrual cycle.

Certainly, in common usage the term 'menopause' is employed very loosely to describe a broad and variable passage of time prior to, during and after the end of menstruation. It is in this sense of a broad and variable passage of time that the term will be used throughout this thesis.

## **AIMS AND STRUCTURE OF THE THESIS**

Given the predominance of negative stereotypes, the previous tradition of restricted public debate or taboo, the relatively recent increase in media discussion and debate, the lack of New Zealand research, and the needs of 'meno-boomers' such as myself,

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<sup>6</sup> Canterbury is the provincial district surrounding and including the city of Christchurch.

<sup>7</sup> Each of these three studies is examined and discussed in more detail as part of the literature review in Chapter 1.

questions arise regarding the menopause views, experience, knowledge and management strategies of New Zealand women. How do they view menopause and does this view vary across age groups? Do most women experience the type of problems that stereotypical and common sense views suggest, and what is the impact of these views on their experience? What are the women's sources of knowledge and what are the implications? Have women, for example, been able to share their experiences or have they been kept private because of a taboo surrounding public discussion of this event? What impact has the identification of menopause as a deficiency disease had on women's knowledge, perceptions and experience? Is menopause being medicalised as feared by Coney or are women resisting this process? If so, in what way? What alternatives are there to the medical management of menopause with HRT and how do they conform to or differ from those strategies previously employed by women? These questions identify some of the issues which will be addressed in this thesis. Although previous New Zealand studies have provided some insights, the questions posed above have remained more or less unanswered. This is especially true of those questions concerning the impact of social forces on women's attitudes, perceptions, expectations and experience.

With the above in mind, this thesis aims to explore the social construction and individual experience of menopause within the New Zealand context. More specifically, the thesis has four objectives:

- to identify and examine the significance of wider social forces on women's perceptions and experience of menopause;
- to explore the impact of the deficiency disease model of menopause on women's perceptions, understanding and experience;
- to identify past and current attitudes, common sense knowledge, myths and expectations towards menopause;
- to establish whether or not there are age group differences in women's experience of menopause.

The thesis investigates the subject from a constructivist/interpretive theoretical perspective. This perspective, discussed in Chapter 2, may be briefly defined as one which recognises the perception and experience of menopause as a social construction

and which accepts normative definitions of the feminine as crucial to social perception and individual experience of menopause.

The thesis begins with a review of the academic literature on menopause published since 1980. Commencing with a brief background examination of selected popular and self-help publications, Chapter 1 classifies and reviews the relevant academic literature in terms of three dominant orientations - biomedical/positivist, humanistic/interpretive and constructivist/critical. In essence, the aim of the chapter is to identify an appropriate theoretical approach for this thesis through critical examination of representative menopause studies from each of the three orientations.

The purpose of Chapter 2 is to introduce and detail the theory and method adopted throughout the thesis. The first section of the chapter examines the assumptions, strengths and limitations of each of the three theoretical orientations employed in the literature review and identifies a hybrid constructivist/interpretive orientation as the theoretical perspective adopted for the thesis. The key concepts employed in the thesis (body politic, medicalisation, biomedical hegemony, common sense, agency and experience) are also introduced and defined. The remainder of Chapter 2 then focuses on describing the study methodology which, in the anthropological tradition, involves a range of fieldwork strategies and data analysis procedures. It should be noted, however, that the two main data sets comprise: i) information gathered via focus groups and in-depth interviews with forty-three women aged thirty and above from the Feilding-Manawatu district, defined as the prime research site; and ii) narratives supplied by twenty-nine other women, aged thirty and above resident throughout New Zealand, in response to an invitation published in a weekly magazine (*New Zealand Woman's Day*).

Controversy and ambiguities associated with medical knowledge set the scene for Chapter 3 which examines the menopause views and clinical management strategies of eight local general practitioners and five Australasian specialist consultants. The chapter aims to identify factors underlying the doctors' views and their implications for both clinical practice and women's experience. It is shown that clinical experience is of particular importance to the formation of contrasting professional views and practice

strategies; the general practitioners view menopause as a life-stage event, whereas the specialist consultants define it as a hormone deficiency disease.

Chapter 4 examines educational programmes and printed material readily available to New Zealand women in order to establish the orientation to menopause presented by such programmes and material. The chapter has three sections and commences with a content analysis of menopause workshops, videos, audio-tapes and printed material. It is shown that medically orientated groups present a deficiency disease view in their programmes and material in contrast with a life-stage approach presented by 'independent groups'. In the second section, the views of the North Island co-ordinator for the New Zealand Family Planning Association are examined and the role and function of menopause education programmes offered by the Association are identified and discussed. In the final section of the chapter, the responses of a small group of Feilding-Manawatu women to four artefacts examined in the content analysis are considered and their juxtaposition of the life-stage and deficiency disease models is discussed.

Having 'set the scene' in Chapters 1, 3 and 4, the remaining four chapters focus on the views and experiences of the women themselves. In Chapters 5 and 6 the views of all the women in the study are explored. Chapter 5 aims to identify knowledge sources and to establish the existence of a taboo surrounding social discussion of menopause. An examination of mother/daughter and woman-to-woman communication on menopause and female reproductive functioning confirms a tradition of taboo and an associated paucity of experience-generated common sense knowledge on the subject. The women's knowledge and their views on the availability and quality of information are discussed in light of the trend towards the medicalisation of menopause.

Chapter 6 commences with the narratives of eight participants which identify mid-life and ageing, loss of fertility and health risk as themes central to the meaning of menopause. Each of these meanings are explored in relation to the women's attitudes, perceptions and expectations. Particular emphasis is placed on the impact of broader socio-historical forces in shaping perceptions of menopause, and the implications for women's health and well-being are discussed.

The focus of the two remaining chapters is on the perceptions and experience of the fifty-two women in the study who defined themselves as 'in' or 'through' menopause. Chapter 7 presents the narratives of sixteen of these women across four age groups; that is, seventy plus, women in their sixties, women in their fifties and women in their forties. The primary aim is to establish a starting point from which to examine and discuss the women's experiences in Chapter 8. Each narrative, selected as representative of the experience of the particular age group concerned, provides a holistic view of the menopause experience and thereby counters the fragmentation that occurs when selected aspects of experience are extracted for the purposes of systematic data analysis.

Chapter 8 focuses on the experience of menopause across four age groups and is designed to identify differences in attitudes, experiences and reflections. The experience of the seventy-plus age group highlights the constraints of stoicism and taboo identified in Chapter 5. For those in their sixties, there were signs that stoicism and taboo were starting to break down and that the implications of treatment for menopause-related symptoms with HRT were starting to emerge. Comprising the largest group of participants, the women in their fifties indicated noticeable social changes and an increased use of HRT for the control of symptoms. Finally, a developing resistance to the impact of the medicalisation of menopause was most apparent among women in their forties who were increasingly opting for alternative management strategies. Overall, the contrasting experiences and views of the four age groups reflect the social changes and developments in medical knowledge that have occurred since the second World War. More significantly, however, the experiences of each age group demonstrate the continuing desire to control the menopausal body as the central aspect of their experience of menopause.

Following a summary of the thesis chapters, the Conclusion provides a schematic integration of the relationship and impact of diverse forces and processes upon control of the menopausal body and the mechanisms for management of women's experience of menopause. This schematic integration places the body politic as central to the experience of menopause in the context of broader socio-cultural and historical processes involving normative definitions of the feminine and forces of knowledge and

power. Finally, the implications of the impact of the body politic on the health and well-being of mid-life women are briefly considered and possible directions for future research are then identified and discussed.

## Chapter 1

### A Conceptual Classification and Review of the Literature

...menopause...is in fact a deficiency disease...a condition similar to diabetes...  
(Wilson, 1966:18)

...menopause is a normal and expected event that leads to a positive perception of health.  
(Buck and Gottlieb, 1991:41)

...[menopause is] the time in a woman's life when she went batty for a couple of years  
and slowly but surely lost it upstairs...  
(Starr, 1992:viii)

...[menopause] happens to every woman. Pregnancy we can choose to go through with or  
not. With menopause there is no choice.  
(Sheehy, 1993:5)

Publication of Wilson's (1966) book *Feminine Forever* stimulated both public debate and academic research on menopause which hitherto had been a socially unmentionable and largely uninvestigated aspect of women's life experience. Since the late 1960s the literature on menopause has been characterised by controversy and contradiction. An uncritical acceptance of cultural perceptions of female sexuality and a biomedical construction of the human body, together with a North American orientation, are dominant features of social research on the topic. The result is that the current state of knowledge concerning the nature and impact of menopause on the lives of women is somewhat spurious and signals a need for alternative directions in research. Indeed, as the first of the post-war 'baby boomers' reach their fifties and at a time when more women than ever before are attaining menopausal status, the need and opportunity for new directions in research is becoming more and more apparent.

Fundamental to any research project are the influence of social values, beliefs and attitudes as well as the research context which includes the researcher, the participants and the target audience. Knowledge, in other words, is shaped by culturally defined norms which reflect the social context within which it is generated. Moreover, the theoretical emphasis and methodological procedures characteristic of different research

orientations exemplify differences in underlying philosophical assumptions and so lead to a divergence of research results. As Holton (1974:120) puts it:

...the study of nature is a study of artefacts which appear during an engagement between [the] scientist and the world in which he finds himself...these artefacts are seen through a lense of theory....different experimental conditions give different views of 'nature'.

The issue of the validity of 'truths' raises the perennially thorny problem of the relationship between truth and reality. From which perspective do we judge? Or is such an activity an exercise in futility? Surely the point must be that all knowledge needs to be recognised as the product of particular socio-historical circumstances. From this perspective, science involves the creation rather than the discovery or description of reality. When knowledge is viewed in this way there is a need for critical appraisal of the assumptions fundamental to any particular theoretical perspective if inherent strengths and weaknesses of any research project are to be identified (Koeske, 1982:3):

...analytical perspectives, assumptions, models of reality are intimately linked with methodology and interpretation....all proceed from or can be organised into some framework of assumptions for imputing meaning to otherwise unordered data points.

Although recognition of knowledge as a transient state may be regarded with trepidation by some or seen as heretical by others, such a view is potentially challenging and insightful as it demands an examination of scientific discovery on its own terms. The outcome is a new and critical look at long accepted tenets of empirical reality and an ability to expose such views for what they are; that is, at best, partial truths.

The purpose of this review is to critically examine the scope of the socially orientated, academic literature on menopause published since 1980. A search revealed literature on the topic which ranged from that directed at a popular or lay readership through to the social and culturally orientated publications as well as the biomedically dominated research. Examination of contemporary and self-help publications identified social values and common concerns associated with the topic and so provided an invaluable source for contextualising this study.

The immediate outcome of the literature search was the realisation that studies on menopause can be classified into three broad categories of philosophical orientation.

Of these, the first is a *biomedical/positivist orientation* which assumes the stable and orderly nature of reality independent of social and cultural forces.<sup>1</sup> From this perspective, attainment of knowledge involves the employment of descriptive, objective, value-free strategies and the application of deductive reasoning. There is an emphasis on replicability, reliability and validity through methodological standardisation and an implicit acceptance of a dualistic construction of the human body which is assumed to function in a uniform and universally experienced manner. The second approach, an *humanistic/interpretive orientation*, acknowledges reality as subjective, fluid and at best partially knowable through interpretation of meaning. Fundamental to a humanistic/interpretive approach is an emphasis on empirical documentation of individual and collective social experience, primarily through the method of participant-observation.<sup>2</sup> Finally, a *constructivist/critical orientation* views reality as a multi-faceted, context dependent, fluid product of human interaction. The central focus of this approach is on social structure and the role of social processes in the construction of values and beliefs, knowledge and practice. Particular attention is given to the implications of power dimensions existing within and between social and cultural groups. Thus a constructivist/critical orientation seeks understanding through analysis of social processes, and the collective action of individuals and groups.<sup>3</sup>

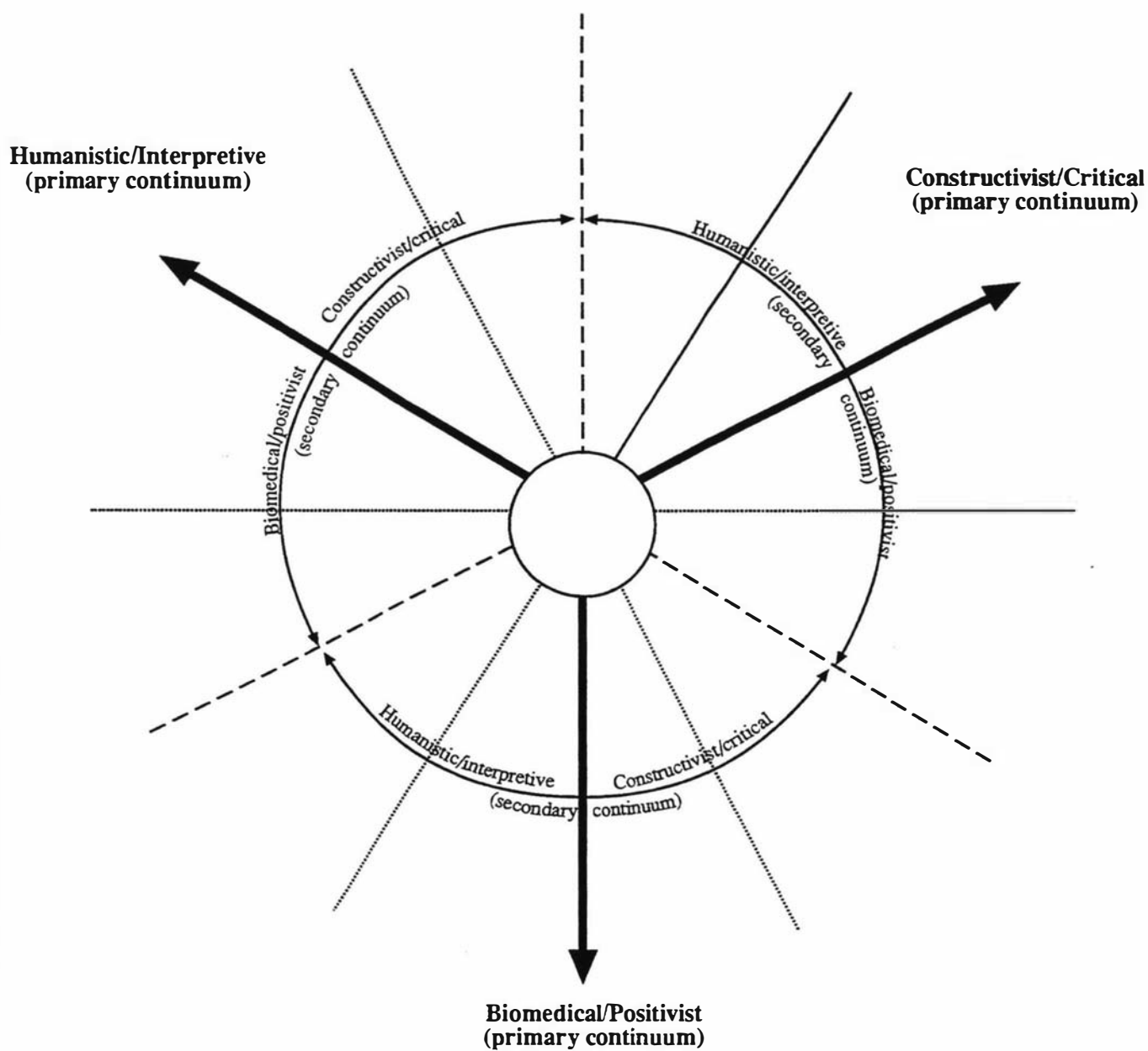
Having identified three philosophical perspectives employed in the social research on menopause, it is possible to graphically illustrate studies representative of each orientation via a qualitative factorial analysis. Each orientation can be represented as a vectorial continuum (the primary vectorial continuum) originating from a hypothetical central point of purist origin (Figure 1.1).<sup>4</sup> The boundaries of each vectorial space are indicated through a series of broken lines with dotted lines delineating areas of theoretical adherence and convergence. The right-angle intersection of each continuum

<sup>1</sup> See Barlow et al. (1991), Friederich (1982), Koster (1991), Dennerstein et al. (1994), Greene and Cook (1980), Morse et al. (1994), Dumble (1992).

<sup>2</sup> See George (1988), Duncan (1995), Davis (1986), Brown (1982), Buck and Gottlieb (1991), Lock (1982), Kaufert and Gilbert (1986), Beyene (1992), SROW (1988), Hamilton (1990).

<sup>3</sup> See Koeske (1982), Duignan (1989), Estok and O'Toole (1991), Coney (1992), McElmurry and Huddleston (1991), Flint (1982a), Griffen (1982), Flint (1982b).

<sup>4</sup> A vector is a quantity that has direction as well as magnitude and so can determine the position of one point in space relative to another (Tulloch, 1994:1742). My use of the concept of vectors allows a dynamic representation that cannot be conveyed through a more conventional representation of fixed elements in space.



**Figure 1.1:** *Vector diagram identifying the three theoretical orientations of the literature on menopause*

by a second vector (the secondary vectorial continuum) provides a two dimensional representation of the degree of adherence and convergence of each study, the inner segment on each side of the philosophical continuum indicating a high degree of theoretical conformity. Clearly, as a graphic representation, the degree of conformity of a study to the ideals and perspective of a particular orientation can at best be only approximate and the possibility of a totally uncontaminated approach is remote.

It needs to be noted at this point that Dickson (1993) uses a similar conceptual framework to the one adopted here. Dickson identifies four paradigmatic approaches - biomedical, socio-cultural, feminist and post-modern - with which to examine and critique research on menopause. Her critique of the application of both the biomedical and socio-cultural paradigms to menopause research raises issues similar to those identified in relation to studies with biomedical/positivist and humanistic/interpretive orientations. She notes the linear, causal focus of biomedical methodology and its emphasis on the manipulation and control of variables and argues that biomedical definition of women (defined as biological products of their hormones) 'lays the groundwork for hormone replacement therapy as a logical and 'scientific choice' for the management of menopause' (Dickson, 1993:54). Socio-cultural methodology is also identified as linear and causal but with the additional focus on social interaction, attitudes and roles (Dickson, 1993:53). Within this paradigm the notion of women as victims of their hormones is rejected and menopause is acknowledged as a natural process involving social responses. In contrast with the constructivist/critical orientation employed in this review, however, Dickson (1993) distinguishes between feminist and post-modern approaches. The focus of the feminist paradigm is on the critical exposure of social conditions of suppression. From this perspective, women are viewed as equal but oppressed and the notion of being victims of their hormones is rejected. The post-modern paradigm directs its attention to textual analysis and the impact of historical and socially specific discourses in shaping social phenomena. From this perspective, menopause is perceived as a physiological transition involving a plurality of experiences (Dickson, 1993: 53).

There are similarities between Dickson's (1993) four paradigmatic approaches and the three orientations identified and employed in the following pages, particularly with

respect to her identification of the biomedical and socio-cultural paradigms. Differences do emerge, however, with respect to: i) Dickson's separation of the feminist and post-modern paradigms; and ii) the ability of the vector model to identify blurred boundaries - a feature which facilitates a more precise identification and examination of the theoretical strengths and limitations of the literature on menopause.<sup>5</sup>

Turning to the examination of the literature on menopause, representative examples of both popular and academic works published since 1980 have been included in this review with priority accorded to Australian and New Zealand material. The discussion will commence with an examination of the popular literature on menopause as this introduces issues of public debate and concern, many of which are investigated further in the academic research. The self-help books examined here will not be classified in terms of theoretical orientation as their purpose is to background lay information available to women and popular views on the subject. Graphic illustration of theoretical orientation will only be applied to the academic literature and is identified in Figure 1.2.

## **POPULAR LITERATURE**

Menopause may be the last taboo... [It is a subject on which] all the obvious sources of information and comfort - mothers, doctors, the media, academics - have shied away from.

(Sheehy, 1993:4-7)

As the introduction has suggested, menopause is a subject that continues to remain largely unmentionable in polite company, and myths and misinformation on menopause abound. Indeed, knowledge on what a woman may expect during this stage of her life has, until fairly recently, been difficult to uncover. The popular literature on menopause which has emerged from the mid-1970s onwards is characterised by its broad scope, embracing topics as diverse as the investigation of commonly held attitudes, values and beliefs towards women, their bodies and their reproductive functioning. In general, this literature falls into two categories. The first is one of self-help manuals while material in the second category presents more critical accounts of women's experience of menopause, mid-life and ageing. Common to both categories are comments on the lack

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<sup>5</sup> This point is discussed further in Chapter 2.

of accessible, reliable information and the proliferation of myths and stereotypic notions. Typical of such comments is the following (MacKenzie, 1984:3):<sup>6</sup>

Why hasn't there been a New Zealand book on menopause before? ...I went through the libraries and bookshops in search of good reference books. There were shelves of books on...just about everything else you could possibly want to know about. But on menopause there was little. What there was had a heavily medical bias, was outdated, distorted and often patronising. The overwhelming feeling from the books available was that women who suffered from the symptoms of menopause usually had too much time on their hands and were basically suffering from not enough to do.

### Self-help Manuals

The first of the popular publications, and important as a forerunner of self-help manuals, was Wilson's (1966) *Feminine Forever*. Wilson's essentially biomedical/positivist approach is fused with a conservative, male chauvinist understanding of menopause, women and their bodies. Described as 'a crusade to rescue women from the 'living decay' of menopause', Wilson's views were derived from his professional experience as a New York gynaecologist treating upper middle-class women and rested on the assumption that such patients were representative of all menopausal women (Coney, 1993:59). The result is an emotive, value-laden treatise on women, their sexuality and the female body which cobbles together medical knowledge and paternalistic attitudes, the latter couched in terms of medical and scientific certainty.

Typical of Wilson's orientation is his conclusion that, as a deficiency disease, menopause results in 'female castration' and so sustains 'drastic' effects on the entire body (Wilson and Wilson, 1963, cited in Coney, 1993: 61):

The unpalatable truth must be faced that all post-menopausal women are castrates...men age, if free from disease in a proportional manner. The pituitary-adrenal axis and thyroid are relatively intact until very old age...a woman is very different. Her ovaries become inadequate relatively early in life. She is the only mammal who cannot reproduce after middle-age.

Although Wilson was dismissed as a crank by many members of the medical profession, his ideas continue to dominate much of the discourse on menopause (Coney, 1993:60). As the first to define menopause in terms of physiological deficiency

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<sup>6</sup> This publication is one of two New Zealand self-help manuals on the topic. The other is Potter (1991).

and to publicly champion the benefits of hormone replacement therapy, Wilson (1966:17) challenged the prevailing perception of menopausal difficulties as being derived from the mind. The result was the stimulation of public and academic debate and, more significantly, identification of menopause as a hormone deficiency disease.

More recent publications in the self-help category tend to be written by women (lay and medical professionals) with the aim of presenting in simple, non-medical language the physiological process of menopause and associated events commonly experienced by mid-life women. The majority of such books detail strategies and interventions for the relief of and/or coping with menopause and mid-life difficulties. In some cases they may also present first-hand accounts of personal experience. An example is Potter's (1991) *Women in Mid-life* which focuses on attitudes towards ageing and the stresses and lifestyle changes commonly faced by mid-life New Zealand women. As with other self-help publications, Potter pays considerable attention to the physiological process of menopause and related health issues and offers advice on matters such as coping with stress, diet and lifestyle enhancement and relationships. Potter acknowledges menopause as an event involving physiological change, social change and diverse experience, but concludes that mid-life is a time of choices and potential for personal growth for the majority of women.

### **Critical Accounts**

Three books (Greer, 1992; Sheehy, 1993; Coney, 1993) have been selected to illustrate popular critical accounts. A leader of the modern feminist movement, Greer (1992) examines the significance of menopause and ageing for women of post-industrial twentieth century society. Greer argues that while female worth remains dependent on women's sexuality, menopause will continue to be regarded as a negative event associated with loss of fertility and physical attractiveness. Accordingly, she portrays the attainment of menopause as a traumatic transition in women's lives, one that necessitates considerable personal adjustment (Greer, 1992:6-7):

...no matter how good or effective the treatment of physical symptoms at the climacteric may be, there are some aspects of being a fifty-year-old woman that cannot be cured and must be endured. Sooner or later the middle-aged woman becomes aware of the change of attitude of other people towards her. She can no longer trade on her appearance, something she has done unconsciously all her life.

Against the constant theme of patriarchal domination, Greer examines the experience of a diverse range of women, including those from other cultures and female literary characters. The biomedical construction of the female body is also examined. For example, Greer's discussion of the attitude of the medical profession towards menopause notes the influence of Wilson and his promotion of hormone replacement therapy as a means of ensuring that women remain 'feminine forever'. To Greer, Wilson's attitude exemplifies the prevailing belief that female happiness is dependent on physical attractiveness and male gratification, and concludes that the pharmaceutical industry's promotion of hormone replacement therapy is merely a new form of patriarchal control and domination of female sexuality.

Greer's central theme of change identifies menopause as a time of major transition involving the reassessment of self-perception and social engagement. Greer (1992) argues that post-menopausal women, as asexual beings, are freed from the shackles of male patriarchy and so have the opportunity to look inward and develop their 'true' selves. Her examination of emotions and events associated with the transition into older womanhood results in an articulate, comprehensive critique of a wide spectrum of issues and historical events associated with female fertility, mid-life and ageing. The outcome is a challenge to re-evaluate accepted stereotypes of the female body, womanhood, menopause and older women.

A sudden, unexpected encounter with both severe menopausal symptoms and the effects of subsequent hormone treatment alerted Sheehy (1993:vii) to the 'fog of inexcusable ignorance...and [the] powerful and mysterious taboo' surrounding menopause. Aware of her own total lack of preparation for the onset of this event, she interviewed a diverse group of American women and discovered that (Sheehy, 1993:24):

Women in mid-life are afraid to know - and fiercely resist acknowledging - that menopause can affect *them*, but...are desperately anxious to learn what it is all about. Privately they will go to extraordinary lengths to pick up information - but heaven forbid anyone should bring up the subject at the dinner table.

Sheehy identified a number of issues of concern to North American women. For example, her investigations revealed that discussion on menopause rarely, if ever, occurs between mother and daughter and at best the mother's answers tended to be

brief and evasive: 'There was nothing to it; my periods just stopped' or 'I don't remember much about menopause' (Sheehy, 1993:26). Other significant issues that emerged included: the loss of sexuality and negative attitudes towards older women; embarrassment, shame and fear associated with the manifestation of symptoms, such as hot flushes; controversy surrounding the issue of hormone replacement therapy; and the notion of a 'wise woman'. Sheehy's technique of addressing issues through accounts of individual experience encourages reader identification with the issues discussed and offers a pragmatic and positive approach to menopause as the gateway to mature adulthood.

Although in many respects a self-help publication, Sheehy's book goes beyond the identification of difficulties and provision of practical remedies for the relief of menopausal symptoms. Underlying her discussion is an attempt to address the politics of menopause via an examination of broader social issues surrounding women's experience of this event. Although journalistic in style and orientated to the experience of North American women, Sheehy does identify issues common to many women of post-industrial societies. In accord with Potter and Greer, Sheehy concludes that negative stereotypes associated with menopause are social rather than biological in origin and emphasises mid-life as a time of potential for personal growth, reassessment and challenge.

A third book in the popular critical account category is written by a New Zealand journalist with a background in social anthropology. Coney (1993:9) seeks to 'explain the politics of medicine's interest in the mid-life woman' through critical examination of the issue of hormone replacement therapy. In the first two sections of her book Coney backgrounds the topic via a discussion of current social attitudes towards menopause and mid-life women. The remainder of the book focuses on current medical attitudes and practices associated with the issues of osteoporosis, hormone replacement therapy and increasing medical management of menopause. Thus a central aspect of her discussion is the argument that mid-life women and menopause are 'the prime target for the new prevention-orientated general practice', and are therefore vulnerable to the process of medicalisation (Coney, 1993:15). Indeed, Coney sees an

increasing tendency for the recognition of menopause as a 'deficiency disease' as evidence of the influence of biomedical hegemony.

In common with Greer (1992), Coney (1993:53) sees the medical management of menopause as based on essentialist notions of women's worth and their well-being. She identifies Wilson as the 'Hugh Hefner of menopause', arguing that Wilson's construction of mid-life women as 'desexed' and 'castrates' signifies social redundancy based on stereotypic notions of female worth. Coney argues that the oestrogen deficiency disease model of menopause is reductionist, simplistic, mechanistic and fails to take account of the views and experiences of women themselves. She cautions that in the absence of alternative medical constructions of menopause, conditions favourable to the marketing of hormone replacement therapy emerge and become established. The outcome is reaffirmation of menopause as a deficiency disease and widespread acceptance of the need for medical management of this event.

Coney is critical also of feminist attitudes towards menopause, mid-life and ageing which she identifies as an over-reaction to the deficiency disease model (Coney, 1993:55):

Against the negative medical stereotype, feminists have sought to rehabilitate menopause by insisting on its normalcy [as] a period of renewal and spiritual awakening...at their most celebratory [feminists] attempt [the] redemptive feat of reclaiming words like 'hag' and 'crone'...that symbolise the visceral revulsion towards ageing women.

She concludes that such a view is removed from the reality of the lives of many women and so serves to consolidate existing confusion among women and to confirm the lack of credibility of feminist perspectives against the influence of medical orthodoxy. Coney's solution involves the need for reaffirmation of menopause as a normal stage of female adulthood and therefore outside the need for routine medical supervision. Indeed, she determines that the disease model of menopause has the potential 'to damage the quality of life of mid-life women', unless accessible, non-biased information is made available and women are consulted about the provision of appropriate mid-life health services and treatment (Coney, 1993:278):

Women need to reject an ideology which leads to a preoccupation with ill-health and which inculcates a sense of precarious mortality....women should insist on their right to live life with verve, gusto and spice.

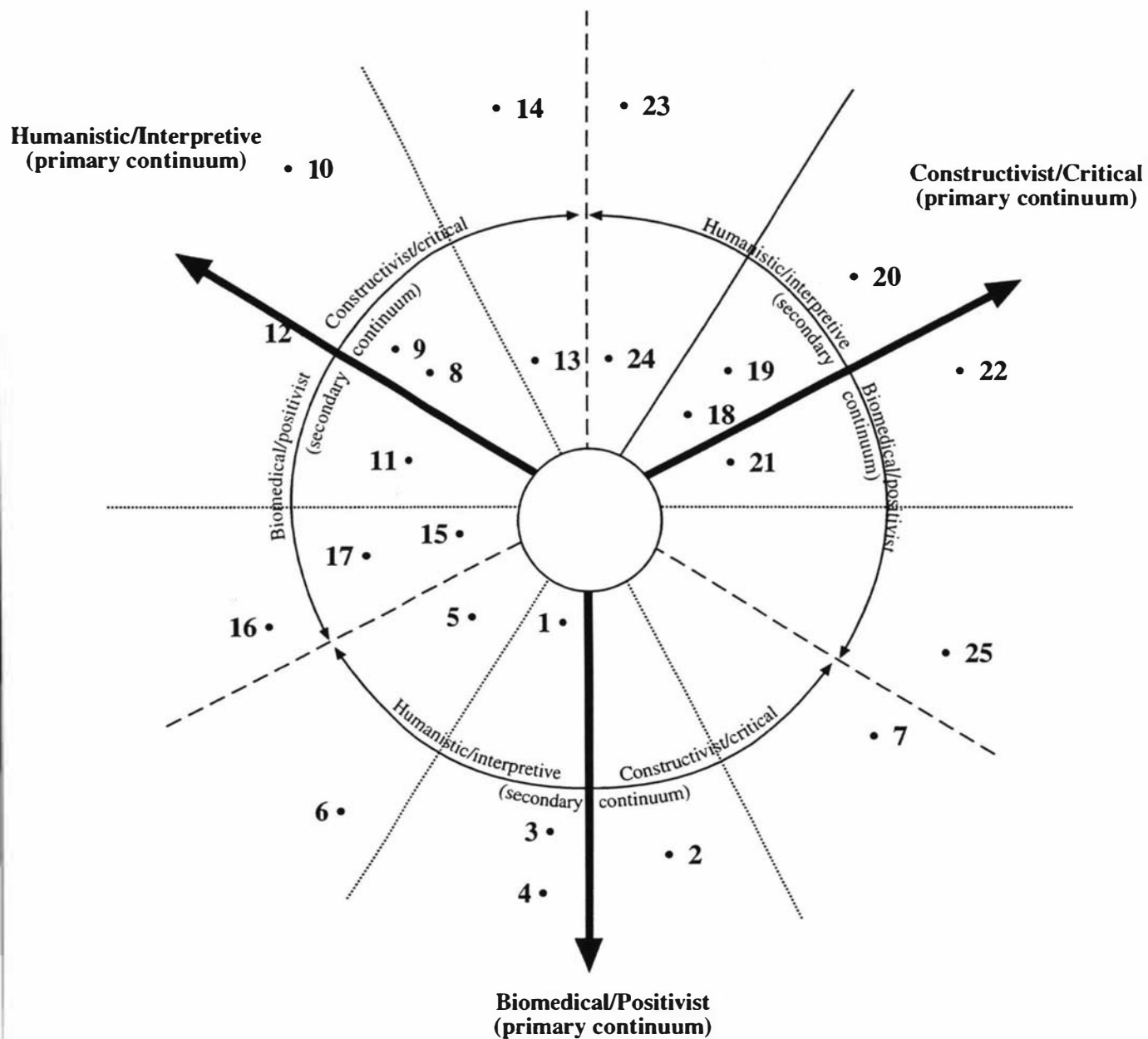
## **BIOMEDICAL/POSITIVIST ORIENTATION**

By far the majority of publications on menopause identified during the literature search were those that met the classification criteria for the biomedical/positivist orientation. It would be an understatement to say that for the purposes of this review the selection of items to be included was a difficult task, especially given the large number available and the broad range of topics and issues addressed. The decision was therefore made to narrow the field by excluding those that focused simply on the physiology of menopause and to direct attention to examples of those publications reporting research which took into account some of the many social aspects of menopause.

Barlow et al. (1991) argued that despite the current high interest in menopause, little was known by general practitioners about the everyday management of this event. In particular the authors were concerned with practitioner prescribing of hormone replacement therapy and its use in the prevention of osteoporosis. The study aimed to provide an alternative to a 'prescribing survey' through implementation of a survey of general practitioners in the Oxford area of England over a six month period. The methodology involved the completion of a post-consultation questionnaire by participating practitioners each time a patient raised menopause-related concerns. Overall, five hundred and seventy-two consultations involving four hundred and sixteen women aged between forty and sixty years were documented.

The study found that: younger women 'often presented' with menstrual cycle disturbances in addition to menopausal symptoms; hot flushes were the most commonly reported symptom but decreased in frequency with age; vaginal dryness was the main problem among women over sixty years but more commonly reported by women under sixty; and women who had had hysterectomies visited the doctor more frequently and reported more symptoms. Although 27 per cent of consultations were confined to discussion and advice, Barlow et al. (1991:276) cautioned that:

Our study does not suggest that substantial numbers of asymptomatic women are consulting their general practitioners to discuss prevention of osteoporosis, as, of the 103 who discussed it, only 12 did not have another climacteric symptom which would have been more likely to have led to the consultation.



- | <i>Biomedical/positivist</i> | <i>Humanistic/interpretive</i> | <i>Constructivist/critical</i>    |
|------------------------------|--------------------------------|-----------------------------------|
| 1. Barlow et al. (1991)      | 8. George (1988)               | 18. Koeske (1982)                 |
| 2. Frederich (1982)          | 9. Duncan (1995)               | 19. Duignan (1989)                |
| 3. Køster (1991)             | 10. Davis (1986)               | 20. Estok & O'Toole (1991)        |
| 4. Dennerstein et al. (1994) | 11. Brown (1982)               | 21. Coney (1992)                  |
| 5. Green & Cooke (1980)      | 12. Buck & Gotlieb (1991)      | 22. McElmurry & Huddleston (1991) |
| 6. Morse et al. (1994)       | 13. Lock (1982)                | 23. Flint (1982a)                 |
| 7. Dumble (1992)             | 14. Kaufert & Gilbert (1986)   | 24. Griffen (1982)                |
|                              | 15. Beyene (1992)              | 25. Flint (1982b)                 |
|                              | 16. SROW (1988)                |                                   |
|                              | 17. Hamilton (1990)            |                                   |

**Figure 1.2: Theoretical location of representative studies of menopause**

The study's focus on the consultation activities of general practitioners precluded investigation of factors which prompted women to seek information and advice about menopause and/or its symptoms. The assumption is that menopause is simply a physiological condition to be treated biomedically without consideration of the social factors which contribute to the definition of menopause and the meaning of symptoms. In other words, the approach taken in this paper signals an uncritical adherence to the medical model of physical well-being. Accordingly, the study can be located within the inner sector of the biomedical/positivist space but on the humanistic/interpretive side of the primary continuum on account of its focus on doctor/patient interaction (see Figure 1.2).

Friederich (1982:336) identified a lack of 'normative data on the concerns of women aged 45-55', as a dilemma for clinicians with regard to the prescribing and assessment of oestrogen replacement therapy. The author drew on the findings of a number of studies on physiological changes associated with the climacteric in order to discuss the impact of menopause on female bodily functioning and to identify possible complications associated with the administration of oestrogen therapy. Friederich (1982:343) concluded that the 'evidence for giving or withholding estrogen replacement to women in the post-menopausal years is conflicting', and advocated individualisation of patient care and the promotion of knowledge of 'the psychosocial setting in which the patient is functioning'.

Although Friederich placed some emphasis on the physio-psychosocial nature of menopause, this paper is, nevertheless, heavily dependent on the language and assumptions of biomedicine. Friederich's central focus on a clinical understanding of the physiological changes associated with menopause, locates this discussion within the inner sector of the biomedical/positivist continuum on the constructivist/critical side of the primary continuum (see Figure 1.2).

Koster's (1991) longitudinal study of the attitudes, expectations and experience of climacterium was based on data from three surveys conducted in 1976, 1981 and 1987, involving a cohort of Danish women born in 1936. Critical of the representativeness and cross-sectional nature of other studies, Koster (1991:2) argued:

Little attention has been paid to the attitudes toward and expectations and experience of the climacterium that women themselves have. Do they share the concept of the change of life as a period of loss, deteriorating health, and declining sexuality, or do they mainly consider it another stage of life?

Koster's study employed mailed questionnaires to seek information on general health issues, socio-demographic data and topics associated with menopause. The results identified: a lack of recognition of menopause as an illness among respondents; confirmed the importance of social and cultural factors for health during the climacterium, and as possible predictors for at risk groups; showed that sexual desire remained constant for the majority of respondents during the menopausal transition; and identified a positive attitude towards the deficiency disease model of menopause through respondent acceptance of the use of hormone replacement therapy in the absence of associated health problems.

Koster (1991:9) concluded that the sample did not support the notion of the 'change of life' as an illness or an event associated with loss of youth. Indeed, she found that most women experienced few problems and dismissed the notion of menopause as a significant event. Koster (1991:11) did, however, identify a positive attitude towards a deficiency disease model of menopause and noted:

...that the respondents seemed to be ambivalent as to whether the change of life should be regarded merely as a physiological process or as a condition requiring medical attention.

Koster's research reveals an inconsistency between respondent rejection of menopause as an illness, but apparent acceptance of a disease model of this event. This finding requires further exploration as it raises the question of what contributes to this inconsistency. What is it about the social nature of menopause that facilitates such a contradictory understanding of this life event? Koster's speculation that women's attitudes are shaped by the direction of current biomedical research on menopause is very suggestive. Although her quantitative methodology limits her ability to explain such a phenomenon, her findings nevertheless provide an interesting starting point for a qualitative study which might be better suited to exploring the ambiguities and contradictions associated with women's attitudes, expectations and experience of the climacterium.

Koster's research provides one of the few longitudinal studies on menopause. Her quantitative methodology does, however, reduce respondent results to statistical patterns and limits her ability to account for the ambivalence in respondent attitudes or documentation of their concerns beyond those explored via predetermined questions and responses. The positivist emphasis of this study locates it in the outer sector of the biomedical/positivist continuum, while the emphasis on exploring women's perceptions of menopause moves it onto the humanistic/interpretive side of the primary continuum (see Figure 1.2).

Located in the same vectorial space as Koster's (1991) study, is one of a limited number of Australian studies on the topic of menopause. Dennerstein et al. (1994) investigated the relationship between menopause and sexual functioning as part of a larger project on the health of mid-life women. The study involved two thousand and one participants who were randomly selected from among Australian-born women aged between forty-five and fifty-five residing in the Melbourne metropolitan area. The aim of the study was to identify links between women's subjective experience, physiological aspects of the menopausal transition and psychosocial variables, through a single telephone interview of approximately twenty-five minutes duration.

The results indicated that although the majority of respondents reported no change in their sexual interest at this stage of their lives, many did experience a 'decline in sexual functioning through the natural menopause transition' (Dennerstein et al., 1994:63). The authors noted that it is not possible in a cross-sectional study 'to establish the etiology of changes in sexual functioning and their relationship to hormone replacement therapy utilization', and recommended the implementation of longitudinal studies on women going through the menopausal transition (Dennerstein et al., 1994:64).

Greene and Cooke (1980:486) drew attention to the 'lack of reliable and valid measurement for assessing symptoms at menopause', arguing that there was general agreement in the literature that not all symptoms experienced by mid-life women are associated with a decline in oestrogen levels. They contended that in the absence of empirical research it remained unclear as to whether such symptoms are indeed

physiological or environmental in origin. Greene and Cooke (1980:486-487) also pointed out that many researchers failed to distinguish between menopause (i.e. the final menses) and the climacterium, noting that the latter involves the prolonged phase of hormonal change before and after menopause itself and so constitutes a 'major period of psychosocial transition'.

Their aim was to investigate the association between symptoms experienced by women during the climacterium and factors such as life stress, social support and adjustment. The research was conducted through semi-structured interviews and self-administered questionnaires among women recruited from within the Gartnavel Royal Hospital catchment area of Glasgow. The results indicated that a small number of women in a broad age range experienced (Greene and Cooke, 1980:490):

...an elevation of psychological and somatic symptoms around the time of the climacterium, [and that] the severity of these symptoms is associated directly with the presence of a high degree of life stress.

On the basis of such a finding, Greene and Cooke (1980:491) concluded that biological factors play a less important role than 'psychosocial changes in life space' in accounting for psychological difficulties experienced by women during the climacterium. The positivist methodology and psychosomatic emphasis of this research project identifies it as biomedical/positivist in orientation, while its emphasis on the psychosocial aetiology of symptoms places it in the inner segment along the secondary humanistic/interpretive continuum (see Figure 1.2).

Morse et al. (1994) presented further findings from the Melbourne Women's Mid-life Health Study described in the research of Dennerstein et al. (1994). The focus of this paper was on factors related to help-seeking and health care utilisation among the research population. Help-seeking was defined as 'a response that centres on introspectiveness or increased attention that is directed internally towards changing body sensations' and the authors recognised this activity as a dynamic process influenced by past learning experiences, cultural patterns and individual ability to tolerate discomfort (Morse et al., 1994:161). The project aimed to establish whether those women seeking treatment during menopause are different from those who do not seek help at this time. Respondent use of formal and informal health care services (the

latter comprising over the counter, non-prescription remedies) was explored and four patterns of activity were identified and classified as those of deniers, delayers, anxious responders and health worriers (Morse et al., 1994:162).

The study results indicated that those women seeking treatment at menopause experienced a range of 'broad psychosomatic symptoms', reported more stress and a history of adverse health. As a group, these women were more likely to be seen by medical practitioners and to be referred on to menopause clinics. The authors voiced concern that such a group, generally comprised of health worriers and/or the psychologically vulnerable, is more likely to be amenable to the offer of hormone replacement therapy for symptom relief than women free of long-term health problems (Morse et al., 1994:171). Underlying such a concern is the knowledge that other studies indicate that only 50 per cent of women seek help for actual menopause related concerns and even lower proportions actually comply with treatment. Morse et al. (1994:171) noted that 'throughout the world, HRT is offered quite indiscriminately to middle-aged women seeking help', and saw such a trend as a critical area for further research. However, as this claim appears to be based on the research findings of a handful of studies conducted primarily in North America, without further investigation it remains speculative. Is, for example, such a claim an accurate reflection of the experience of New Zealand women?

The notion challenged by Morse et al. (1994) is that menopausal women are a homogeneous group experiencing seriously disturbed health. Indeed, the authors urged 'greater caution...when pronouncements are made about the typical profile of the menopausal woman' but nevertheless concluded that most often those women seeking help at menopause are those with a previous history of health-related problems (Morse et al., 1994:172). The result is a profile of treatment seeking women whose regular contact with health professionals makes them more likely to be reported in the scientific and popular literature. Thus the notion of menopausal transition as a marker of disease, distress and disability is perpetuated. The quantitative methodology and epidemiological orientation of this study place it in the outer sector of the primary biomedical/positivist continuum, but the focus on treatment seeking behaviour and

health care utilisation move it towards the end of the secondary humanistic/interpretive continuum (see Figure 1.2).

Dumble (1992) overviewed a selection of papers with the intention of highlighting inadequacies in hormone replacement research and the risks associated with replacement therapy. The safety of hormone replacement therapy was claimed to be in doubt and Dumble (1992:15) argued for a moratorium on the use of such treatment 'until [such time as] the purported risks and benefits [can] be resolved'. In common with Koster (1991) and Coney (1993), Dumble expressed concern over research findings which identify the majority of women on oestrogen replacement as those already medicalised in their reproductive health through contraceptive pill use and rates of hysterectomy.<sup>7</sup>

Critical of the perceived bias toward the promotion of HRT by the medical profession, Dumble rejected accusations of scaremongering in the popular press and drew attention to recent research which warned that the physiological risks of oestrogen should be clearly indicated to women before use. For example, Dumble noted recent identification of a risk of drug dependence associated with HRT and pointed out that the findings of a preliminary research project indicated a significant number of women come off HRT in response to personal recognition of the addictive nature of the treatment.<sup>8</sup> Dumble reacted with concern to the suggestion that women contemplating HRT should undergo a psychological test to determine susceptibility to dependence (Bewley and Bewley, 1992). She concluded with the following remarks (Dumble, 1992:19):

I myself am touchy enough these days, without being evaluated according to some chart in a manual of psychiatric disorders in order to qualify for an HRT prescription. In the face of that threat alone, surviving the big M[enopause] without the big M[yth] of modern medicine, HRT, seems highly recommendable.

Biomedical/positivist in orientation, the critical emphasis of this paper locates it in the outer segment along the secondary constructivist/critical continuum (see Figure 1.2).

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<sup>7</sup> [O]estrogen Replacement Therapy was the original hormone treatment prescribed by Wilson and others. The hormone, obtained and synthesised from the urine of pregnant mares, is known as Premarin. An identified link with uterine cancer in the mid-1970s led to the combination of oestrogen with progesterone, commonly referred to as Hormone Replacement Therapy (HRT).

<sup>8</sup> See Bewley and Bewley (1992) and Klein and Dumble (1992).

## HUMANISTIC/INTERPRETIVE ORIENTATION

Publications with a humanistic/interpretive orientation are typically produced by social scientists - usually anthropologists, psychologists and sociologists. The items selected for inclusion in this review were those judged (among the numerous examples available) to best represent the orientation and particular positions within it. Where appropriate, priority was given to Australasian material.

George (1988:109) argued that although the cessation of menstruation at menopause is universal, women's experience of this event is influenced by cultural values, beliefs and meanings. George (1988:110) explored the meaning of menopause among fifty immigrant Sikh women aged thirty and upwards in Canada using the research technique of:

...listening to...descriptions of their expectations and experiences surrounding mid-life, menopause and climacteric, as well as the importance attributed to these events in their lives.

Among the women studied were those still menstruating regularly but closely approaching menopause. This group provided 'rich insight regarding expectations toward their impending menopause' which, without exception, was looked forward to as 'a period of being clean and free', liberated from 'the pads and mess' (George, 1988:112). They regarded menopause as a normal, healthy and problem-free event (as it had been for their mothers before them). Such attitudes were endorsed by other women in the group who were either menstruating irregularly, had stopped a short time previously or were identified as 'post-menopausal'. Indeed, 'post-menopausal' women associated the attainment of menopause with a sense of fulfilment manifest most frequently through the comment 'we have done our duty' (George, 1988:113).

George suggested that the positive attitudes held by these Sikh women towards menopause are linked with the removal of cultural notions of impurity associated with menstruation; release from the duty and pressure to bear children; and attainment of a certain status and freedom as an older woman in the household. Given the pressure on young Sikh wives to bear children, menopause may not be such a positive experience for a childless woman, however a lack of such women among the research population made it impossible to explore this area. George (1988:115) concluded that:

...the meaning of menopause held by these Sikh women with all of its positive accompaniments must have contributed to the lack of psychological symptoms and their positive outlook toward menopause and middle-age.

The influence of cultural values, beliefs and practices in shaping the meaning of menopause for Indo-Canadian Sikh women is effectively demonstrated. Of interest to the current project also is the author's identification of the impact of mothers' attitudes on their daughters' expectations and the focus on cultural and ideological aspects of menopause. George's avoidance of quantitative survey instruments and physiological reductionism identifies this paper as located in the inner segment of the humanistic/interpretive vector on the constructivist/critical side of the primary continuum (see Figure 1.2).

Sharing the same vectorial location as George (1988) is a New Zealand study which employed 'a feminist methodology' to examine the perceptions and experiences of menopause among a small group of women from the greater Wellington area (Duncan, 1995: 43). The data for this study was obtained from a series of three focus groups and ten in-depth interviews involving urban, lesbian and rural women aged between thirty-three and sixty-two years. A range of attitudes and experiences were identified with most of the participants viewing menopause as a positive event. While many expressed relief at the end of menstruation, some felt that 'along with the loss of periods' they had lost their femininity (Duncan, 1995:77). Among the small group of lesbian women, connections were drawn between menarche, menstruation and menopause and a desire was expressed 'to mark the end of menstruation with...ritual...to [celebrate] women's special ability to bear children' (Duncan, 1995:76).

Overall, the study found that the women's experience of menopause involved a wide range of symptoms of varying degrees of severity. Many of the women required no relief for their symptoms and there was a general resistance to the medical management of menopause through HRT. Moreover, the women did not accept (or believe) the medical recommendation that women should be on 'HRT from the peri-menopause to their death' (Duncan, 1995:100). The theoretical location of this study on the constructivist/critical side of the primary continuum of the humanistic/interpretive vector reflects its limited scope and the author's failure to adequately interpret or

critically examine and account for the women's views and experiences. This study is, however, one of only a few which have addressed the attitudes and experiences of New Zealand women toward menopause. Despite its limitations it provides a starting point for further research and indicates clearly the significance of agency when women do not passively accept the medicalisation of this life event.<sup>9</sup>

Davis (1986) drew on her fieldwork experience among the women of Grey Rock Harbour, Newfoundland, to reflect on the strengths and weaknesses associated with emic and etic strategies of menopause research.<sup>10</sup> Biomedical reductionism, an emphasis on identification and measurement of symptoms, and the formulation of standardised instruments were identified as characteristic of etic research. While Davis acknowledged the ability of socio-cultural etic research to undertake random sampling of large populations, she argued that such methodologies were inadequate to the task of gaining insight and understanding of women's experience of menopause (Davis, 1986:75):

The experience of middle-aging is embedded in tradition, folk culture, societal values and the social construction of knowledge. One of the most important cognitive features of the lay health system is that it cannot be understood apart from every day reality and every day common sense and knowledge.

Methodological difficulties encountered by Davis during her own period of fieldwork, alerted her to possible limitations associated with the use of etic strategies when exploring the socio-cultural aspects of menopause. For example, her attempt to complete standardised questionnaires was hampered by low literacy rates among her respondents and it forced her to administer the questionnaires orally.<sup>11</sup> As a result, Davis encountered resistance to direct questions on personal, intimate matters where such behaviour was generally considered unacceptable. Moreover, Davis found that many of the women were unable to accept questions at face value and responded as if being tested on intelligence or morality, a reaction that she felt influenced the answers

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<sup>9</sup> The concept of agency is defined in Chapter 2.

<sup>10</sup> The object of an emic strategy is to describe and understand that which is meaningful to the 'other'. In contrast, an etic perspective seeks to describe and explain, through the application of theoretical models, individual and social experience (Abrahams, 1986:57).

<sup>11</sup> Davis (1986:85) notes that, 'Questionnaire data...came from oral administration of the Socio-cultural Patterns and Involutional Crisis [SPIC] interview schedule developed and used by the Datan Consortium (1981), and the Neugarten (1963) Attitudes Towards Menopause [ATM] checklist'.

provided. Davis also found herself frequently instructed by the respondents to answer questions in the way she considered most appropriate given her knowledge of the woman concerned. Finally, when the participants were required to give a numerical response (for the ranking of feelings or experience) they seemed to be ambivalent and many appeared to be unable to articulate their feelings in this manner. Consequently, Davis (1986:91-92) concluded that:

Although I collected questionnaire data in as conscientious and responsible a fashion as I felt was possible I have little reason to expect that my quantifiable data is either reliable or valid.

Davis raises some important issues concerning methodological assumptions and the collection of data associated with positivist, etic research models. Most notably, she graphically illustrates the need to engage a methodology appropriate to both respondent circumstances and the aims and objectives of the study concerned. In her view, therefore, insight and understanding of individual and social experience is best achieved through application of emic research methodologies. Emic methodologies allow a more flexible approach to data collection, can prevent reductionism and allow the collection of data which acknowledges and accommodates individual variation and complexity. Moreover (Davis, 1986:76):

Understanding the folk, popular or lay dimensions of menopause cannot take place apart from understanding the role of the local community in the process of negotiating meaning of aging in the social and symbolic contexts of village life.

Davis's critical examination of emic and etic research methodology, empirical orientation and emphasis on collective and individual meaning identifies this paper as humanistic/interpretive in orientation and located in the outer space on the constructivist/critical side of the continuum (see Figure 1.2).

Brown (1982) focused on the theme of discontinuity in women's lives as they age beyond the childbearing years. The author drew on numerous ethnographies to illustrate the position of middle-aged women in a variety of cultural situations, and identified 'overwhelmingly positive changes' associated with fewer social restrictions and attainment of greater authority and status beyond the household sphere. Indeed, Brown (1982:143) argued that negative attitudes toward female middle-age evident in Western culture are an exception.

Brown (1982:144) noted that the majority of researchers link positive changes in the social position of middle-aged women with the removal of contamination associated with menstruation and an associated need to protect female fertility. In many cultures, middle-aged women are considered asexual and so are freed of male authority and domination. As a result, norms of modesty and restricted access to public places and male company are relaxed and the woman acquires status and power within the household and possible community recognition through involvement in roles such as midwife, matchmaker or curer.

Brown drew attention to variation in the change of lifestyle experienced by mid-life women and noted the traditional anthropological focus on issues of inheritance and protection of property as a means of accounting for such variation. While acknowledging their ability to account for the diversity of change, Brown argued they fail to satisfactorily address the matter of discontinuity in the lives of older women. Attention is thus drawn to insights offered by sociobiology and psychoanalysis which recognise (Brown, 1982:148):

The mother-offspring bond [as] a lifelong part of the panprimate heritage, reinforced by ideals of behaviour which are apparently universal and, in some societies, by the continuing association of mother and food.

Brown concluded that the enhanced status of middle-aged and older women is separate from their social role.

Brown's use of the term 'middle-aged' in place of 'menopausal' represents a deliberate attempt to avoid a physiological focus on mid-life and a rejection of a biomedical explanation of menopause. Such a strategy, however, appears to be contradicted by her reliance on a sociobiological explanation for the discontinuity in women's lives. It may also be noted here that a number of Brown's assumptions and conclusions are challenged in commentaries appended to her paper. Of particular note are those which question the author's assumption of the universal nature of the mother/child relationship, the coincident end of fertility and childrearing, and an association of loss of fertility with improvement in status. Such ideas are seen as disregarding the cultural construction of motherhood, practices of adoption and the position of childless women in cultures where female status is dependent on motherhood. Moreover, the

supposition that older women in non-Western societies generally enjoy greater opportunities and an increase in status, in comparison with their Western sisters, is refuted as inaccurate and representative of a romanticised, idealised and ethnocentric view generated from a culture preoccupied with the desirability of youth. Nevertheless, Brown's extensive use of ethnographic material and the critical appraisal of traditional anthropological explanations of cultural variations in bodily experience locate this paper in the inner space of the primary humanistic/interpretive vector on the biomedical/positivist side of the continuum (see Figure 1.2).

Buck and Gottlieb's (1991) work as nurses among Mohawk women alerted them to the need for research on the meaning and experience of menopause among healthy women. They argued that 'The lack of studies embedding menopause and child-launching within the total experience at mid-life and the use of 'clinical' populations in research studies have produced a decremental view of women at mid-life' (Buck and Gottlieb, 1991:43). Accordingly, a grounded theory approach was employed to examine the meaning of menopause and mid-life among Mohawk women. It was found that Mohawk women perceive mid-life in terms of 'time for me', 'being where I should be', 'time for myself' and 'spen[ding my time] meaningfully' (Buck and Gottlieb, 1991:41). In other words, these women saw mid-life as a time of change in their priorities with a shift in attention away from others and on to themselves. Central to such a view was the expectation of conformity to a 'timetable' of events involving assumptions such as no longer having children living at home.

Buck and Gottlieb concluded that the significance of time accounted for variations in the mid-life experience of Mohawk women. The emphasis on a trajectory of events made mid-life potentially problematic for the women if circumstances failed to unfold in the anticipated sequence. In such cases, a woman's experience became either a challenge or a threat. Thus the real issue for mid-life Mohawk women was one of personal development rather than biological change. Overall, the focus on women's experience and the avoidance of a 'decremental' explanation place this paper midway along the primary humanistic/interpretive continuum (see Figure 1.2).

Lock (1982:261) presented preliminary research findings on 'the relationship of the beliefs and practice of individual clinicians to knowledge contained in medical texts, and the cultural construction of clinical reality in connection with menopause'. Fundamental to the project was a recognition of disease as a product of social values and perspectives, and identification of the link between historical and contemporary attitudes towards women and gynaecological practice.

Lock drew attention to a shift in the literature on menopause; a shift away from nineteenth century links with disease, in favour of conflicting models of this event as a deficiency disease or biopsychosocial phenomenon. Characteristic of each of these models is the lack of consensus over true signs and symptoms of menopause and an enormous variation in the sequence and form of biological events. Lock (1982:269) saw the result as one of confusion regarding the exact nature of menopause and hence ambiguity with regard to appropriate treatment strategies. In such a climate, Lock argued that clinical decisions are likely to be influenced by non-medical factors which can be broadly categorised as: the clinician's personality, personal attitudes, values and social circumstances; past and ongoing professional training and access to educational resources; and wider social influences such as those of the patient population, mass media and impact of the health care system.

Lock's study of the practice of twelve gynaecologists, twelve family practitioners and five residents in obstetrics and gynaecology in the Montreal area confirmed her suppositions. The clinical response of each practitioner towards menopause was classified as either biomedical in orientation, biopsychosocial in orientation or unclear/undecided. Lock (1982:272) found that the individual who was the most biomedically orientated of all the physicians: viewed menopause as a 'time of loss'; performed endometrial biopsies in order to 'scientifically' determine a woman's menopausal status; and regarded prescription of oestrogen as the easiest way to deal with the effects of menopause. A man in his mid-sixties, this physician believed the role of the gynaecologist to be one of diagnosis and treatment of specific physical symptoms in as 'scientific' a fashion as possible. In the clinical setting this practitioner consistently objectified his patient and did not once present what he supposed to be the patient's point of view (Lock, 1982:273). In contrast, clinicians with a biopsychosocial

orientation saw little point in performing endometrial biopsies; did not routinely prescribe oestrogen treatment; and focused on the psychosocial aspects of menopause, particularly in relation to the ageing process. This group of clinicians, who were generally in a middle-age range and included a woman, were more likely to assess symptoms as social rather than biological in origin and frequently referred patients to appropriate social agencies for help in dealing with problems.

Lock (1982:276) concluded:

It is clear from the present study that the biomedical information available on menopause is open to numerous interpretations, and that in the clinical situation, depending upon the attitudes and values of the physicians, *either* the benefits *or* the problems associated with the medication may be emphasized, or not discussed at all.

Lock (1982:270) also noted the lack of scientific principles and the constant modification on which working clinical models of menopause are based. She argued that such factors made it clear that individual physicians tend to work from folk rather than biomedical models as the basis of decision making, models which are culturally constructed and therefore modifiable by economic and cultural variables.

The emphasis on the influence of culture on medical knowledge and the empirical investigation of clinical decision-making places Lock's (1982) study in the inner space of the humanistic/interpretive continuum at the far end of the secondary constructivist/critical continuum (see Figure 1.2). Lock's identification of the relationships between folk models and clinical practice endorses points made by others as noted earlier in this literature review. For example, Coney (1993) links the medical ideas of Wilson (the originator of the deficiency disease model of menopause) with personal values and attitudes about the role of women, while Friederich (1982) points out the lack of normative data on the concerns of mid-life women as a dilemma for clinicians when prescribing hormone replacement therapy. Thus Lock's claim that medical knowledge is culturally informed emerges as a key factor in any analysis of the construction of menopause as a medical 'fact'. The point is that the biomedical construction of menopause does encompass and reflect deeply embedded social values and beliefs. It is therefore vulnerable to change and modification, controversy and confusion, and (contrary to popular belief) personal rather than value-free appraisal within the clinical and research situation.

Kaufert and Gilbert (1986) drew on data from a Manitoba project on the health of women in mid-life to ascertain whether menopause has been medicalised. Defining medicalisation as 'a process whereby more and more of everyday life has come under medical dominion, influence and control', Kaufert and Gilbert (1986:7) queried the validity of applying such a concept to menopause, noting:

Menopause is often included with childbirth and menstruation in the list of examples used by critics when arguing that medicine has co-opted and transformed the natural processes of women's lives....[this] presumes a similarity in the degree to which they are all medicalized.

They argued that evidence of the medicalisation of menopause in a manner akin to that of childbirth required two factors to be established: first, the existence of a medical model of menopause equivalent to that applied to childbirth; and second, the imposition of the medical model on women's perception and experience of menopause. An examination of the biomedical model of menopause revealed a contrast between the broad medical definition of menopause as 'the period of time preceding and following upon the last menstrual cycle' and the more recent, reductionist emphasis on oestrogen deficiency as the central focus. Kaufert and Gilbert noted that the implications of such a shift in emphasis were manifest in the gynaecological literature where the deficiency model was acknowledged as fully representative of the reality of menopause and so went unrecognised as an 'abstract scientific entity'. The result was the conversion of a normal process of ageing into a disease and potential health hazard and so menopause knowledge, management and treatment was transferred to medical control, thereby increasing the likelihood of women being prescribed hormone replacement therapy.

Kaufert and Gilbert argued that the most crucial aspect of the process of medicalisation of menopause involved evidence of the disease model being imposed on women. An examination of data from the Manitoba project to determine the extent to which women depend on their own or a physician's judgement regarding menopausal status and whether menopause is regarded as an event requiring medical management, indicated diverse responses from women and their physicians. Indeed, the authors noted certain similarities with the findings of Lock's (1982) research. Overall, menopause was not a highly medicalised process for the women of Manitoba, as only a small proportion of the women came under the management of a physician. To be more specific, Kaufert and Gilbert (1986:15) stated that while 60 per cent of the peri-

and post-menopausal women in the study had experienced hot flushes 'only 33 per cent had discussed hot flushes with their doctor and only 25 per cent of these with this symptom had been prescribed estrogen replacement therapy'. Accordingly, Kaufert and Gilbert (1986:16) concluded that 'if estrogen use is taken as the key measure of medicalization, then the extent is limited'.

This conclusion led Kaufert and Gilbert (1986:17) to a fundamental question:

Why are women and their physicians apparently freer to accept or reject the biomedical model for menopause, but not for childbirth and what does this mean for understanding medicalization as a process?

Kaufert and Gilbert suggested that because menopause occurs at the end of a woman's reproductive life it is an event that is generally neither the subject of community concern nor pressure. However, they warned that the situation might well change 'as the argument about health care costs to society of not protecting women against osteoporosis becomes more strident' (Kaufert and Gilbert, 1986:19). Women may then no longer be able to make a choice as to whether or not to treat their menopause as a medical event and take oestrogen. In this respect, the paper identifies a significant political implication of the construction of menopause as a disease model and the potential for this event to develop into an important aspect of the body politic.<sup>12</sup> Finally, it may be noted that the focus on the medicalisation of menopause identifies the study as humanistic/interpretive in orientation and located in the outer space of the continuum towards the end of the secondary constructivist/critical vector (see Figure 1.2).

Beyene (1992) argued that ethnographic research on menopause is characterised by its rarity, inconsistency, anecdotal and peripheral nature. Moreover, the analysis of the 'scanty' cross-cultural data was seen as (Beyene, 1992:169-170):

...inadequate and reflecting middle-class, Western cultural values, expressing a tacit notion that new roles for women, such as participation in male activities, are a universal measure of status gain for all women.

Beyene's point is that attempts to distinguish between women's experience of menopause on the basis of social and cultural factors alone is misleading.

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<sup>12</sup> The concept of the body politic is defined in Chapter 2.

In an attempt to overcome the shortcomings of previous cross-cultural research on the topic, Beyene developed a research strategy involving an extended period of fieldwork over three years. She studied rural Mayan Indians in Mexico and rural Greek women on the island of Evia, in order to compare the (Beyene, 1992:170):

...natural history of the menopausal experience of women in two non-industrialized cultures where there is no hormonal therapy for the physical and emotional changes said to occur.

Beyene found both similarities and marked differences between women in the two cultures. For example, both groups perceived menopause as a time of increased freedom from former taboos and social restrictions as well as from the fear of unwanted pregnancy. Each culture accorded an increase in respect and power to the aged. Among Mayan women, menopause went unrecognised except as the marker of the end of menstruation and childbearing and was not associated with physical or emotional symptoms. Indeed, Mayan women looked forward to the end of menstruation and so anticipated menopause as a positive event. Greek women, on the other hand, experienced menopause in a manner that 'seem[ed] to bear more resemblance to [the] experience of American women described in the medical literature' (Beyene, 1992:173). Thus, despite relief from social taboos associated with menstruation, Greek women associated menopause with health difficulties and physiological symptoms such as hot flushes and accordingly perceived it as a negative experience.

Beyene accounted for the contrast in attitudes and experience among these two groups in a number of ways. For example, the impact of diet on menopausal symptomology was suggested as a possible factor with regard to the difference in the average age of onset of menopause. The significant difference in fertility patterns was also noted, and the possibility of a link between repeated pregnancies and lack of menopausal symptoms among Mayan women was suggested. Other factors considered included the impact of genetic factors and the importance of cultural values and social conditioning in the management of and attitudes toward physical symptoms. Beyene's (1992:176) point was that hormonal factors alone are insufficient to account for the diversity in menopausal experience. The author concluded that further research is necessary and advocated the implementation of studies which consider the impact of biocultural

factors such as environment, diet, genetic and fertility patterns on the production and equilibrium of women's hormones. In general, the participant-observation fieldwork methodology identifies this study as humanistic/interpretive in orientation, however its emphasis on the role of hormones in determining menopausal experience locates it at the end of the secondary biomedical/positivist vector in the inner segment of the vector space (see Figure 1.2).

The Society for Research on Women (SROW) has a tradition of social research carried out by interested volunteers on a wide range of issues relevant to New Zealand women. One such project investigated experience at mid-life among a group of Christchurch women via a general questionnaire administered to a statistically non-representative sample of respondents. A dominant aspect of the project was the health status of respondents and recognition of mid-life as a time of depression as motherhood is left behind and children leave home. In addition to broader aspects of life, questions also explored expectations of menopause, the incidence of hormone related symptoms, helpfulness of treatments, alternative treatment and stereotypic notions of menopause. The results obtained led SROW (1988:67) to conclude:

Our survey results showed no significant association between mid-life symptoms and the life stresses nominated in the survey....There was also no association found between stresses and menopausal stage.

Although predominantly a quantitative study, this project yielded some insight into individual experience of menopause among New Zealand women. For example, it identified a number of general attitudes and beliefs associated with mid-life experience and established that there was little evidence of negative attitudes towards menopause among the women interviewed. In fact the majority of respondents had apparently given little thought to menopause or were unconcerned about its approach. Only about half of the four hundred and forty-four participants felt they might encounter difficulties with menopause and there was a low incidence of severe hormone-related symptoms reported. Indeed, those women who did report severe symptoms were predominantly recruited through their voluntary attendance at a general practitioner's surgery for consultation on symptoms experienced (a phenomenon consistent with the

findings of the Melbourne study).<sup>13</sup> For the majority of respondents, therefore, mid-life was perceived as a positive stage of their lives.

The SROW study is significant as one of the very few pieces of New Zealand research on mid-life, identifying useful background information and areas of future research. For example, while the majority of respondents viewed menopause as 'no big deal', the impact of medical knowledge on women's perception of this event was nevertheless apparent (SROW, 1988:66). Many of the participants associated menopause (stereotypically) with cancer, pregnancy, loss of libido and losing one's mind. In their concluding remarks, the researchers acknowledged the impact of 'medical debate on many of the matters touched on in this report' and noted the difficulty associated with identifying mid-life symptoms as hormonal or social in origin (SROW, 1988:66). Finally, with regard to its classification, the quantitative methodology of this study places it in the outer segment of the humanistic/interpretive space, while the emphasis on physical symptoms and biomedical definition of bodily change places it towards the end of the secondary biomedical/positivist continuum (see Figure 1.2).

Located in the same vectorial space is another, primarily quantitative but smaller New Zealand study. Using a survey which employed both closed and open-ended questions, Hamilton (1990) investigated and compared the attitudes and experience of menopause and mid-life among sixty-four Canterbury women aged between forty-five and fifty-five years. The aim was to investigate 'possible relationships between menopausal status and physical and psychological symptoms and certain personality and demographic variables claimed to be relevant to the menopausal experience' (Hamilton, 1990:1).

The questionnaire explored a range of issues which included: the extent to which the women viewed menopause as 'pathological'; links between menopause and depression and sexuality; perceptions of others towards menopausal women; and the women's fears about menopause. Aside from the statistical presentation of results, Hamilton (1990:119) identified 'four consistent themes' in the women's responses. These

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<sup>13</sup> See Morse et al. (1984).

involved generally positive attitudes towards menopause, a variety of patterns of mid-life experience, an absence of a widespread 'empty-nest' reaction at mid-life and the importance of the availability of alternative roles to those of wife and mother for mid-life women. Hamilton (1990:123-124) also found little evidence that the women surveyed accepted 'the extreme medical model that portrays menopause... as a disease' particularly as only 53 per cent thought it was necessary to see a doctor during menopause. Hamilton (1990:124) concluded that although the respondents did not view menopause as a medical event, they did perceive it as 'a potential hurdle [and] a time of risk and danger'.

### **CONSTRUCTIVIST/CRITICAL ORIENTATION**

Publications with a constructivist/critical orientation are typically viewed as post-modern in perspective and frequently reflect the influences of Marx, Foucault and the work of feminist writers.<sup>14</sup> Once again there was a broad range of material available for review. In accord with the selection criteria employed for the two previous orientations, priority was again given to Australasian material and to those studies with features that were deemed to best represent the orientation and positions within it.

Koeske (1982) sought to formulate an alternative, integrated approach to research on menopause through critical examination of biomedical and behavioural science models of menopausal 'reality'. Critical of the positivist, objective orientation of the scientific model, Koeske argued that links between analytical perspectives, methodology and interpretation render the notion of true objectivity unattainable. Accordingly, Koeske regarded the biomedical focus on the physiological and psychological symptoms associated with a decline in oestrogen levels at menopause as reductionist and simplistic.

Directing attention to what is termed the behavioural sciences model, Koeske identified three orientations.<sup>15</sup> The first, the Premorbid Personality Model, presents a

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<sup>14</sup> See, for example, MacPherson (1981), Bell (1987), Barbre (1993), Dickson (1993) and Zita (1993).

<sup>15</sup> Koeske (1982:5) defined behavioural science models as 'those models which proceed from a greater concern with psychological and past or current social environmental factors than the simple biological models'.

psychological focus which emphasises personality characteristics as the prime determinant of menopausal symptoms. Second, the Coincidental Stress Model examines the significance of external stresses on menopausal experience. Finally, the Cultural Relativist approach focuses on cross-cultural, societal and historical factors, and the influence of cultural stereotypes on menopausal experience.

The strength of behavioural models is their ability to avoid the reductionism of positivist scientific models. Koeske cautioned, however, that such models remain dominated by the biomedical model in the following ways. First, through a focus on menopausal symptoms which has (Koeske, 1982:9):

...the effect of complicating the basic biomedical model by providing loopholes that explain the non-universality of menopausal symptomology...they actually serve to perpetuate important aspects of the biomedical framework...rather than to provide a serious challenge to it in its current form.

Second, through uncritical acceptance of a one-to-one relationship between social structure/environment and experience; a trend that Koeske (1982:9) believed parallels biomedical appreciation of the relationship between hormone deficiency and individual behaviour. He contended that the ability of behavioural models to counter biological determinism was constrained by the impression of a lack of commonality of experience across groups of menopausal women. The result is the reduction of menopausal experience to 'the simple and automatic enactment of societal prescriptions' (Koeske, 1982:9). Third, there is an uncritical adherence to 'Cartesian dualism [which] has plagued Western thought' (Koeske, 1982:10). There is a tendency therefore for behavioural science models to overlook the impact of social environmental factors on biology. And fourth is the unmodified adoption of a biomedical distinction between 'normal' as non-problematic and 'abnormal' as indicative of malfunction.

Koeske (1982:10) saw a need to progress beyond 'the simple hormone-behaviour or social environment-behaviour links' dominating biomedical and behavioural models, and called for recognition of the complex nature of body-behaviour relationships. Accordingly, Koeske (1982:14) supported dimensional and interactive rather than oppositional analysis, such as that apparent in the mind/body split. Five operational guideposts or heuristics were detailed as a means of implementing a biosocial approach to research on menopause. These involved first, a central focus on embodied

experience and second the adoption of a systems approach so that, 'pathways toward experience up from the level of biochemistry and down from the level of culture and social context' could be traced (Koeske, 1982:16). The third advocated an analysis of specific changes associated with menopause in order to independently identify biological and socio-cultural causal factors. The fourth and fifth advocated respectively the inclusion of both physiological and psychosocial variables in the same study and the creation of models of reality which are significant to both medical and behavioural science (Koeske, 1982:17).

Koeske's (1982) analysis of theoretical approaches to the study of menopause conforms to a constructivist/critical orientation and can be located in the inner segment on the humanistic/interpretive side of vectorial space (see Figure 1.2). His promotion of an integrated approach implies a non-reductionist, holistic orientation unattainable from a purely positivist perspective. The difficulty with the proposal, however, is the lack of critical examination of assumptions underlying scientific investigation of bodily functioning and change. Thus the proposed merger of biological and social approaches is more likely to constrain research through an accepted emphasis on the tangible, measurable aspects of menopause and so risks the reduction of social phenomena to measurable physiological outcomes. In other words, the social aspects of the research will conform to the assumptions of the biomedical model and it seems likely that little additional insight will be generated.

What is required is a critical examination of the realist model of reality and the impact of positivism on the biomedical model.<sup>16</sup> For example, Koeske (1982:9) recognised that behavioural models 'seek to explain more or less the same phenomena as do the biomedical models i.e. menopausal symptoms', and qualified this statement with the comment that the focus on symptoms can provide 'loopholes that explain the non-universality of menopausal symptomology'. However, Koeske failed to recognise that the latter may serve to perpetuate biomedical dualism. Moreover, his comments project

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<sup>16</sup> See Chapter 2.

an uncritical acceptance of the biomedical assumption of universality of bodily functioning and experience.<sup>17</sup>

Also located in the same vectorial space is one of the few New Zealand papers on menopause. Duignan (1989) drew on a range of social literature to explore assumptions which surround the experience of menopause and the negative impact of myths and stereotypes on this event. In common with Sheehy (1993), Duignan identified menopause as a normal stage of ageing that marks the beginning of a new phase of women's lives. Duignan argued that such a view is counteracted by the medicalisation of menopause, common acceptance of menopause as an unpleasant event and lack of an alternative to biomedical knowledge on the subject. The result is the perpetuation of negative perceptions of menopause and an adverse effect on women's experience of this event.

Duignan (1989) contended that negative stereotypes associated with menopause are based on misinformation maintained through the traditional emphasis on women as mothers and homemakers. Accordingly, she argued the need to challenge traditional role models assigned to women and to promote more positive attitudes towards menopause by 'influencing the ways in which knowledge about ageing and menopause is generated and used, and through policy making' (Duignan, 1989:7). There remains a need to demedicalise menopause, counteract negative stereotypes and myths associated with this event, and for positive change in attitudes towards older women. Clearly influenced by American feminist writers, Duignan's argument reflected ideas and trends identified outside the New Zealand scene. The result is a rather superficial overview of certain themes dominant in feminist and critically-orientated literature on menopause. Although Duignan simplistically cites the influence of the Plunket Society in promotion of the myth of women's primary role as homemakers within New Zealand, the generalised focus of the discussion offers little insight into stereotypes and myths that may exist in this country or indeed their impact on the experience of menopause for New Zealand women.

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<sup>17</sup> See Manning and Fabrega (1973).

Estok and O'Toole (1991) focused on the significance of meanings attached to menopause which they argued (Estok and O'Toole, 1992:27):

...influence how women respond to menopause, how others respond to women they believe are experiencing menopause, and the kind of health care the women receive.

Three categories of meaning were distinguished: natural and normal; deviant; and illness. The construction of menopause as 'natural' and 'normal' has already emerged as a common theme in this literature review and needs no further introduction. Estok and O'Toole attributed such notions to feminist writers within the United States. In contrast, the idea of menopause as 'deviant' presented a new perspective and involved the belief that women have control over symptoms associated with the menopausal transition. As a result, middle-aged women who fail to conceal certain types of behaviour risk social sanctions, isolation and accusations of bothering others, and may even be classified as 'crazy' in extreme cases. Situations such as the latter may result in calls for a person to be 'sent away' (Estok and O'Toole, 1991:32).<sup>18</sup>

Classification of menopause as an 'illness' involved notions of legitimacy, illegitimacy and associated stigma. Estok and O'Toole pointed out that, as a deficiency disease, menopause is regarded as a legitimate complaint in need of medical intervention. In contrast, menopause as an illegitimate illness is linked to perceptions of decrepitude and decay and to certain discreditable behaviour. As an illustration, Estok and O'Toole cited the example of Jane Byrne, Mayor of Chicago, who in 1977 came to the public's attention when she spoke out against political corruption in the city. 'It was reported in the press that some of her opponents explained the attack on the political machine as merely being due to the 'change of life'' (Estok and O'Toole, 1991:33).

Although all mid-life women go through menopause, Estok and O'Toole (1991:36) noted that there appeared to be conflict over the meanings of this event and understanding had to be sought within 'the larger gender system in our society'. They argued, for example, that one outcome of a heightened awareness of the impact of meanings attached to menopause could be a decline in the rhetoric involving notions of

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<sup>18</sup> The themes of deviance and insanity associated with menopause emerge strongly in *Women of the 14<sup>th</sup> Moon: Writings on Menopause* (Taylor and Sumrall, 1991). In a section labelled 'Sweet Insanity', this volume of menopausal vignettes presents a variety of accounts of menopause-related 'insanity', menopausal women feeling out of control, acting in unusual ways and being institutionalised for behaviour perceived as abnormal.

'women's raging hormones'. They concluded that as social constructions, meanings have social, political and economic consequences and so impact on health care providers, policy makers and researchers. Significant in this paper, is the identification of constructions of menopause as 'deviant' and an 'illness'. The dominance of the biomedical deficiency disease model promotes such prejudicial constructions of this event and draws attention to the value of alternative approaches which highlight the impact of social factors on bodily experience. The orientation of this paper locates it in the outer space of the constructivist/critical continuum on the humanistic/interpretive side of the vector (see Figure 1.2). The outer vectorial space position reflects the authors' use of earlier personal research in addition to a search of the literature for meanings attached to menopause.

Coney (1992) presented a case study of the process of medicalisation through an examination of women's use of and attitudes towards hormone replacement therapy in New Zealand. As an active member of an Auckland woman's health group,<sup>19</sup> Coney (1992:4) associated constant requests for advice on menopause-related medical tests and treatment with the 'unrelenting message of doom and gloom' linked with this event. Coney argued that many of the messages creating anxiety in women emanate from the lay media and are accompanied by an 'invitat[ion] to abolish the source of their 'troubles' by the simple expedient of taking a pill every day' (Coney, 1992:4). With confusion in the medical literature surrounding the possible risks and adverse effects associated with hormone replacement therapy, the promotion of such treatment downplays any disadvantages.

Coney saw the aggressive marketing of hormones as instrumental in the medical redefinition of menopause as an oestrogen deficiency disease and pointed out that deeply embedded cultural attitudes about the proper roles of women buttress such a perception. The outcome is the expansion of the boundaries of menopause into a 'permanent condition to be permanently managed' and the belief that hormone replacement reinstates a 'normal' state of physiology for older women (Coney, 1992:5). However, Coney (1992:7) concluded that:

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<sup>19</sup> Women's Health Action Trust and the Women's Health Information Service.

Research findings do not support the current ideology and definition of menopause. Women are told that they will dread getting older, regret menopause, and feel less feminine and useless as they age, but these are socially-constructed expectations, rather than being grounded in women's own experience and attitudes.

She insisted that the marketing of hormone treatment capitalises on cultural values attached to youth and women's fear of ageing, and encouraged women to resist the view that they must overcome the normal process of ageing in order to maintain their status (Coney, 1992:10). Coney's paper is significant for its New Zealand perspective and succinct critique of the medicalisation of menopause. It is located within the inner sector of the constructivist/critical space, on the biomedical/positivist side of the primary continuum (see Figure 1.2).

McElmurry and Huddleston (1991) examined the literature on self-care to establish whether such literature reflected important tenets of women's health as defined by the Chicago School of Thought in Women's Health (1986).<sup>20</sup> Their goal was to foster research which 'develops knowledge that helps prevent illness, prolong life, and promote and enhance well-being' (McElmurry and Huddleston, 1991:15).

The main discussion in this paper followed a short overview of nursing research on self-care and addressed the notions of 'natural menopause' and 'lived experience and menopausal status'. McElmurry and Huddleston (1991:18) pointed out that a common definition of natural menopause as a 'developmental marker or point of change in a woman's life...the endpoint of the reproductive option for women', results in non-integrated research with a focus on physiological events. They noted that more recent medical attention to the notion of menopause as a syndrome, despite employment of multi-variate approaches as a compensatory technique, had accentuated the reductionist nature of the research. Other areas of concern included the employment of 'biased perspectives of ageism, sexism, social (no-effect) models, biomedical models, and biological reductionism' all of which excluded and discounted women's actual experience (McElmurry and Huddleston, 1991:20). The outcome was that 'knowledge about menopause [becomes] enmeshed in myths, misconceptions, and misinformation' (McElmurry and Huddleston, 1991:21).

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<sup>20</sup> See Webster et al. (1986).

McElmurry and Huddleston (1991) called for interdisciplinary approaches which emphasise women's experience as an alternative to biomedically orientated research on menopause. Their conclusion reflected the central theme of self-care through advocating the need to combine (McElmurry and Huddleston, 1991:23):

...tenets of self-care with research on menopause in nursing research and practice [in order to]...help women establish their health goals, add to understanding of universal truths or knowledge of women's development, recognise women as complex biopsychosocial beings who exist within a cultural context, and acknowledge that women own the menopause experience.

The critical but applied emphasis of this paper locates it in the outer space of the constructivist/critical vector on the biomedical/positivist side of the primary continuum (see Figure 1.2). The paper's value lies in its promotion of a holistic, multi-perspective approach to research on menopause and the critical appraisal of both biomedical and social research on the topic.

Flint (1982a) advocated an anthropological approach to research on menopause, the climacteric and middle-age, arguing that it would generate an awareness 'of the overlay of culture on how menopause is expressed....In fact, it has been shown that aging is always viewed culturally' (Flint, 1982a: 175). Critical of the synchronic nature and paucity of research on mid-life and menopause within anthropology, Flint called for investigation into the 'dynamics of ageing cross-culturally', and for the implementation of longitudinal studies of mid-life through to old age. Such strategies would focus attention on socio-cultural, psychological and physiological changes in women's lifestyles and promote understanding of menopause within the cultural context of middle-age and ageing.

Flint's discussion closed with an example from her own research on middle-aged women in the United States which found that medical and psychological perspectives were unable to account for all problems faced by women at this stage of their lives. Indeed, she noted that the women frequently (Flint, 1982a:178):

...complain[ed] of fatigue, yet their physicians say they are healthy; they don't want to see a therapist because they don't feel they either need one or want one for the types of problems they face. They lack energy, they 'feel their age'.

Flint concluded that the 'dynamics of middle age studies...[offer] the researcher the opportunity of utilizing various types of anthropological fieldwork methodology' and

the chance to gain a more comprehensive understanding of menopause, climacteric and ageing (Flint, 1982a:179). Her identification of the need for alternatives to biomedical research on menopause locates this paper in the outer constructivist/critical space, and the emphasis on investigation of the social experience of menopause and ageing places it towards the end of the secondary humanistic/interpretive continuum (see Figure 1.2).

Like Koeske (1982), Flint overlooked the need for critical appraisal of methodological assumptions associated with empirical research. Indeed, she failed to note the reductionist tendency of quantitative methodologies traditionally employed in longitudinal research which document cultural phenomena in the form of patterns and trends. What is required, therefore, is a critical assessment of the assumptions of scientific research if alternative ways of knowing are to be formulated and applied to the investigation of women's experience of menopause.

Griffen (1982) argued that the term 'menopause' projects a medical-clinical definition of an event more accurately described as the 'change of life', and that common usage of 'menopause' had redefined this event to such an extent that it was difficult to discuss it in other than medical terminology. The outcome was that women were deprived of a 'meaningful label for menopause as a social and cultural experience', and therefore may experience isolation from 'the community of femininity' (Griffen, 1982:248).

Griffen's exploration of cross-cultural perspectives on menopause highlighted a diversity of cultural values, attitudes and a lack of homogeneity on the status of post-menopausal women. Griffen (1982:256) pointed out that in the United States, menopause was commonly both dreaded and recognised as an inevitable stage in the ageing process. The impact of such ambiguity was manifest through attempts to postpone the inevitable through an emphasis on the appearance of remaining youthful. Thus medical intervention through administration of hormone replacement therapy and advertising by the cosmetic industry represented a cultural response to an anti-ageing bias. Women were consequently denied the opportunity to age 'naturally' and menopause was endorsed as a clinically-orientated event involving difficulties severe enough to warrant medical help. Under such circumstances, Griffen predicted that

menopause would remain (in the United States at least) an event which changes life rather than being one involving 'a change of life'. Accordingly, Griffen (1982:257) concluded that changes associated with perceptions of menopause 'occur only through a filter of cultural expectations'. The focus on the relationship between the cultural construction of female mid-life, ageing and women's experience of these events, places this paper in the inner space of the constructivist/critical continuum but located toward the extreme of the humanistic/interpretive secondary continuum (see Figure 1.2).

Like Griffen (1982), Flint (1982b) was also interested in the use, misuse and meaning of the term 'menopause'. Flint (1982b:363) argued that the term more correctly referred to the 'one-time phenomenon [of the] last menstrual cycle' and its misuse reflected difficulties of definition. Common usage of the word occurred in three ways: first, as the prolonged period of menstrual change and eventual cessation experienced by mid-life women; second, as the notion of climacteric of which menopause is only one aspect; and third, in relation to symptoms associated with the decline in reproductive functioning and ageing itself. Flint, briefly reviewed studies on menopause undertaken since the early 1960s and identified a need for cross-cultural research which assesses the impact of culture on menopausal symptoms. She saw the latter as culturally induced and reflective of the status of older women in a particular society.

Flint's distinction between primary and secondary symptoms at menopause indicates an acceptance of biomedical classification of 'true' or primary menopausal symptoms as those 'proven' to be associated with a decline in oestrogen levels (namely, hot flushes, profuse sweating and atrophic vaginitis). In contrast, secondary symptoms (which she found to be lacking at menopause among Rajput women of Rajasthan and Himachal Pradesh) are classified as non-universal and non-specific in origin and therefore unrelated to physiological processes or change. Such a view privileges biomedical knowledge as the basis for cross-cultural comparison of the physical aspects of menopausal experience by accepting a dualistic and uniform construction of bodily functioning and experience (hallmarks of the medical model). Flint's (1982b) paper is therefore located towards the end of the biomedical/positivist vector in the outer segment of the primary constructivist/critical continuum (see Figure 1.2).

## CONCLUSION

Focusing upon literature published since 1980, this review has critically examined and classified selected examples of the research on menopause into one of three theoretical orientations, namely: biomedical/positivist; humanistic/interpretive; and constructivist-/critical. Attention was drawn to the impact of social forces in shaping the nature and direction of academic enquiry, and the discussion commenced with an overview of the popular literature as a means of contextualising the topic. A reaction to the disease model of menopause emerged in this popular literature, indicated by the provision of both medical and alternative views on the meaning and management of menopause. In the self-help publications, for example, Potter (1991) emphasised menopause as a normal life transition and advocated lifestyle changes and strategies as alternatives to the medical management of mid-life problems. Similarly, among the more critical accounts, Greer (1992), Sheehy (1993) and Coney (1993) focused on menopause and mid-life as a time of change and challenge. Greer's view of menopause as a time of loss of youth, fertility and sexuality reflected a feminist approach, in contrast with Sheehy who saw menopause as the gateway to mature adulthood. Coney, on the other hand, focused on the politics of menopause through an examination of the development and promotion of hormone replacement therapy. In this way, the popular literature signalled wider social attitudes to mid-life women and the significance of mid-life and menopause in their lives.

The prominence given to the biomedical explanation of menopause (as a state of hormonal decline) in much of the literature results in a tension between medical and alternative constructions of menopause, mid-life and ageing. Integral to the alternative constructions are issues of knowledge, power and control of the female body, sexuality and normative definitions of what constitutes the feminine in both the popular and academic literature. In the group of papers selected as representative of a biomedical/positivist orientation, the positivist emphasis and an unquestioning acceptance of the assumptions of medical science provided a reductionist view which offered little insight to or understanding of a woman's perception and experience of menopause. The positivist emphasis of this orientation held true even at the extremes of both secondary continuums and within the adjacent primary vectorial space (see Figure 1.2). The humanistic/interpretive orientation, on the other hand, was

characterised by a focus on individual understanding and the social meaning of menopause. Towards the end of the secondary constructivist/critical orientation continuum the focus incorporated the impact of social phenomena on individual experience and shared similar characteristics with studies located in the adjoining constructivist/critical sector. Characteristic of the literature with a constructivist/critical orientation was the focus on social structure. The demonstrated strength of this orientation was its ability to recognise all social phenomena as culturally constructed and to identify dominant cultural values, beliefs and attitudes as potential instruments of power. A more detailed examination of the characteristics and theoretical implications of each orientation is presented in Chapter 2.

## Chapter 2

### Theory and Method

The focus and scope of the literature on menopause identified in the previous chapter illuminates three dominant orientations on the subject. The first section of this chapter critically examines and evaluates the fundamental assumptions and characteristics associated with a biomedical/positivist orientation (see Figure 2.1); a humanistic-/interpretive orientation (see Figure 2.2); and a constructivist/critical orientation (see Figure 2.3) in order to identify the theoretical approach adopted in the thesis. Six important concepts are then defined and the remainder of the chapter describes and examines the methodological strategies employed during the collection, processing and interpretation of data.

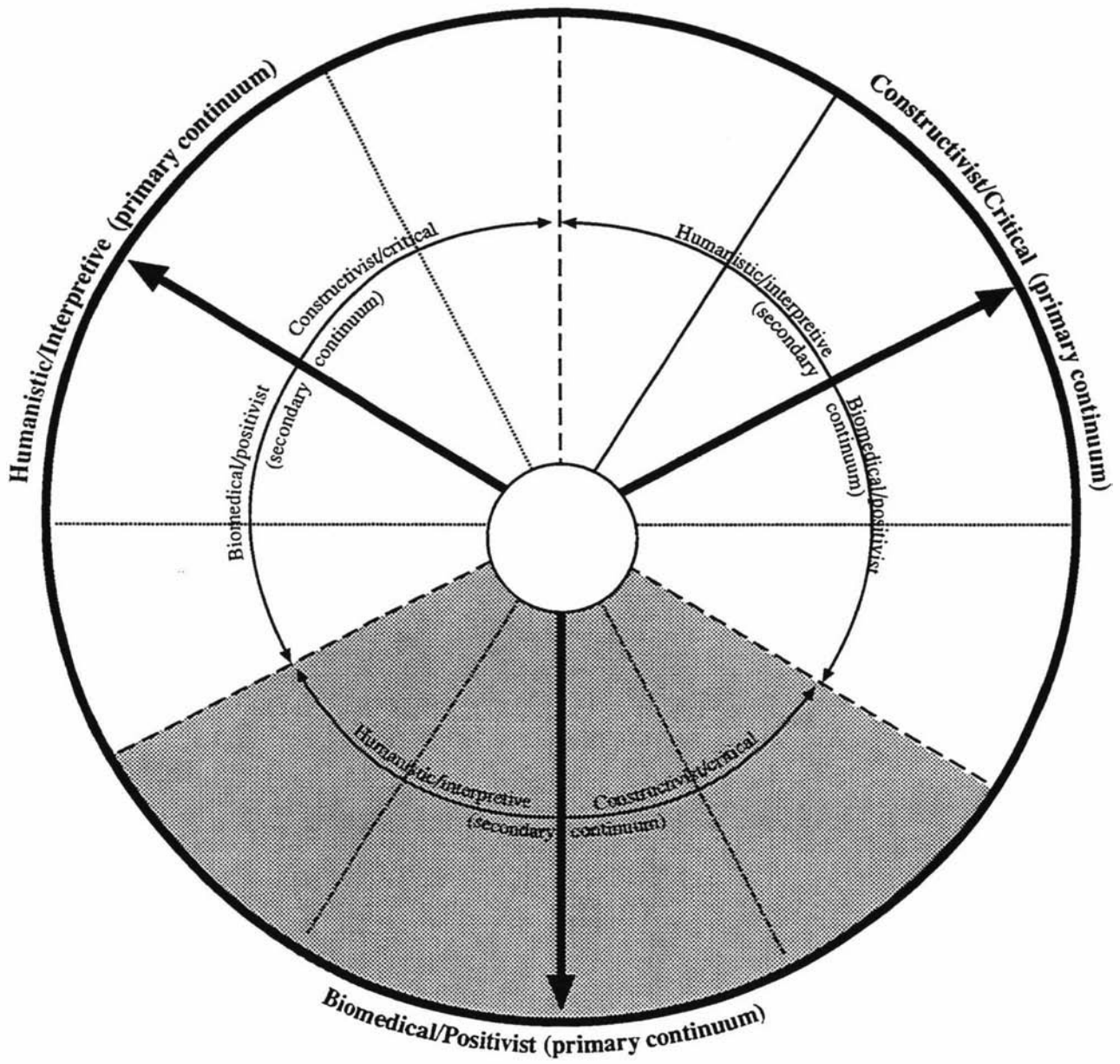
#### THREE THEORETICAL ORIENTATIONS

As indicated in the literature review, although theoretical assumptions hold true within the inner designated vectorial space of each of the three orientations, a degree of convergence occurs along their adjoining boundaries and within the outer sectors (i.e. the sections between the dotted and broken lines) of each vectorial space. The point that should be emphasised, therefore, is that theoretical orientations are not always clearly defined nor are they immune from the influence of others. Indeed, Sayer (1994:73) contends that:

The extent of redundancy and unresolved tensions within theories is underestimated, as are the areas of overlap between them on which there is agreement or indifference.

#### **Biomedical/Positivist**

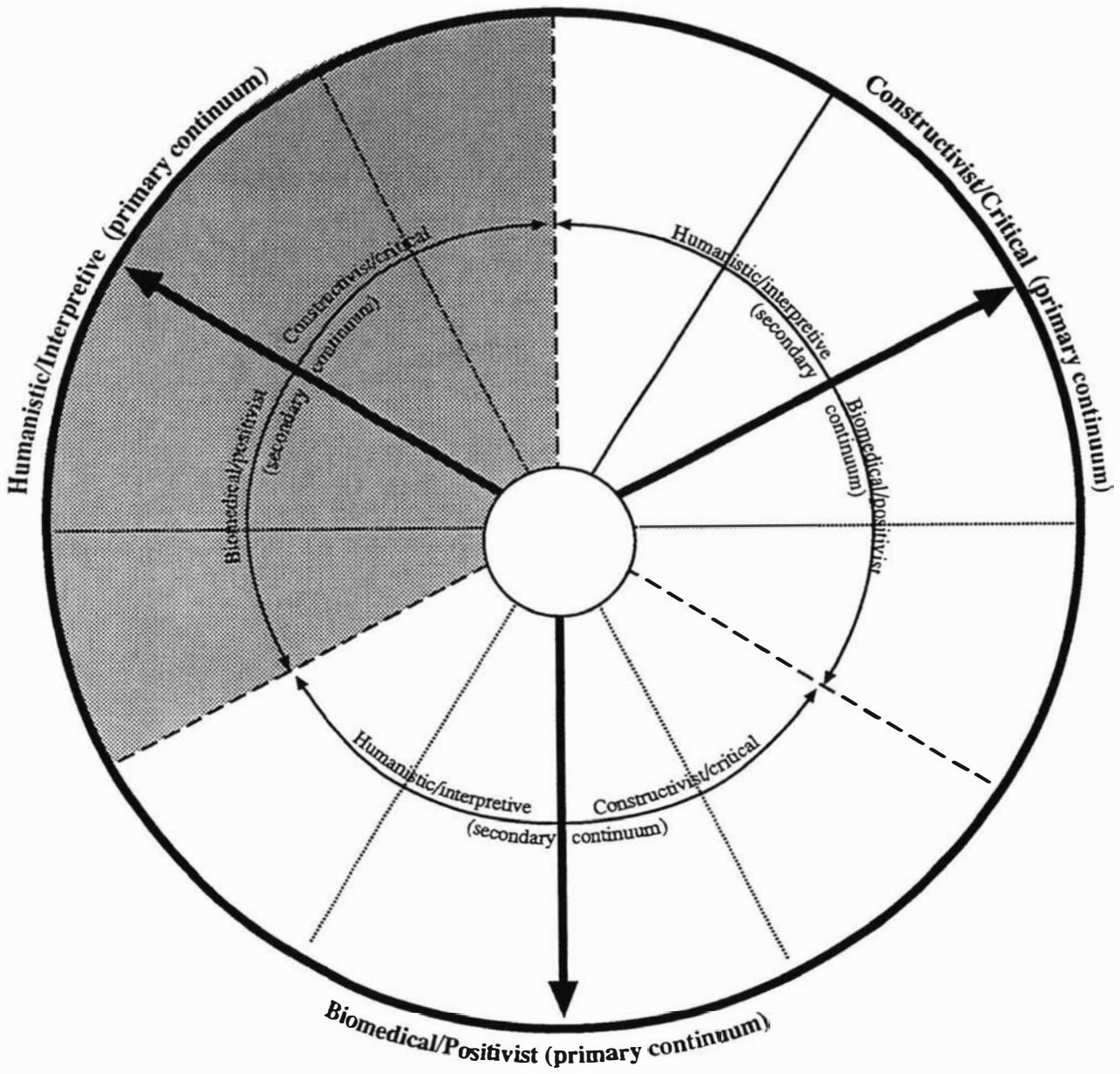
Grounded in the assumptions of the enlightenment, the biomedical view recognises illness as a natural phenomenon and the human body as nature's human representative, knowable through application of the principles of science (Gordon, 1988:24). Fundamental to the biomedical perspective is a mechanistic, dualistic view of the body as a series of separate but interrelated functioning parts which operate independently of the mind. There is also an assumption of universality of physiological functioning and experience, and an emphasis on biological processes, disease and malfunction (Manning and Fabrega, 1973).



*Figure 2.1: Biomedical/positivist orientation*

Underpinning the biomedical view is the positivist mode of inquiry which assumes that nature is independent of culture and that scientific inquiry is value-free. The essence of positivism lies in its focus on the verification or falsification of theoretical propositions through employment of the logic of experiment and analytical reasoning (Guba and Lincoln, 1994:106). Characteristic of positivism is: a deductive explanation of natural phenomena through reference to universal laws; an emphasis on the directly observable; the manipulation of variables; the assumption that regular relationships identified between variables hold across all relevant circumstances; and finally, methodological rigour, with an emphasis on validity, reliability and objectivity (Hammersley and Atkinson, 1995:3-4). The aim of positivism is to facilitate the prediction and control of natural phenomena via the accumulation of knowledge through a process of accretion and the identification of probable facts and laws, and cause/effect relationships (Guba and Lincoln, 1994:113).

Pulling together the biomedical view and the positivist mode of inquiry, the biomedical/positivist orientation is characterised by the documentation and quantification of clinical and lay attitudes, knowledge, management and practices associated with health, illness and physiological functioning. The assumption that nature is external to culture signals a realist explanation of reality, involving a rigid distinction between subject and observer which allows 'the unbiased scientific mind [to] confront a neutral cosmos in a distant, analytical relation' (Best, 1991:193). Accordingly, a biomedical/positivist orientation offers a reductionist explanation of the body and its functioning which not only disregards the subjective, experiential, social and cultural aspects of individual experience of health and illness but purports to describe nature 'as it is'. There is a risk of distortion as statistically meaningful data are deemed to be representative of particular phenomena. Also at issue is the possibility of abstracted probabilities being mistaken for concrete facts, and of data being manipulated to fit established scientific 'facts'. Moreover, the privileged status accorded the scientist/observer ignores the interactive nature of the relationship between observer and subject, and conceals the context within which 'facts' are generated (Guba and Lincoln, 1994:106).



*Figure 2.2: Humanistic/interpretive orientation*

Characteristic of the studies identified in the literature review as biomedical/positivist in orientation (see Figure 2.1) is the focus on menopause as a physiological process of hormonal change accompanied by a range of tangible symptoms. The methodological emphasis for the studies located on the humanistic/interpretive side of the biomedical/positivist primary continuum, is on the identification of patterns and trends associated with the attitudes, practice and experience of women, health professionals and the management of menopause.<sup>1</sup> Alternatively, studies located on the constructivist/critical side of the primary biomedical/positivist continuum examine and challenge the validity of clinical research on the medical management of menopause.<sup>2</sup>

The insights generated by studies with a biomedical/positivist orientation are constrained by their emphasis on medically defined physiological changes associated with menopause and an uncritical acceptance of the value-free, objective and reductionist nature of positivist inquiry. Koster (1991), for example, while critical of the methodology of other studies, assumes that an accurate representation of women's perceptions and experience can be obtained through quantification of survey responses. On the other hand, Dumble's (1992) critique of clinical findings on the safety of HRT, focuses on flaws in medical research methodologies without consideration being given to the context of the scientific inquiry.

### **Humanistic/interpretive**

A humanistic view is an umbrella term for a range of approaches which focus on the explanation and understanding of the actions and experience of individuals and social groups.<sup>3</sup> Accordingly, a humanistic view emphasises agency and the subjective which it seeks to understand and explain through consideration of the socially symbolic and meaningful.

Interpretive inquiry engages in empirical collection of data primarily through unstructured procedures such as participant observation, case histories or informal

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<sup>1</sup> See Barlow et al. (1991), Koster (1991), Dennerstein et al. (1994), Greene and Cooke (1980), and Morse et al. (1994) as located in Figure 1.2.

<sup>2</sup> See Friederich (1982) and Dumble (1992) as located in Figure 1.2.

<sup>3</sup> For example, phenomenology and symbolic interactionism.

interviews. In contrast with positivism, interpretive inquiry does not privilege the observer, claim to represent 'the facts' or emphasise the identification of patterns and trends. Instead, interpretive inquiry produces situated knowledge. That is, knowledge elicited through the dynamics of a specific observational situation, as described by Denzin (1989:11):

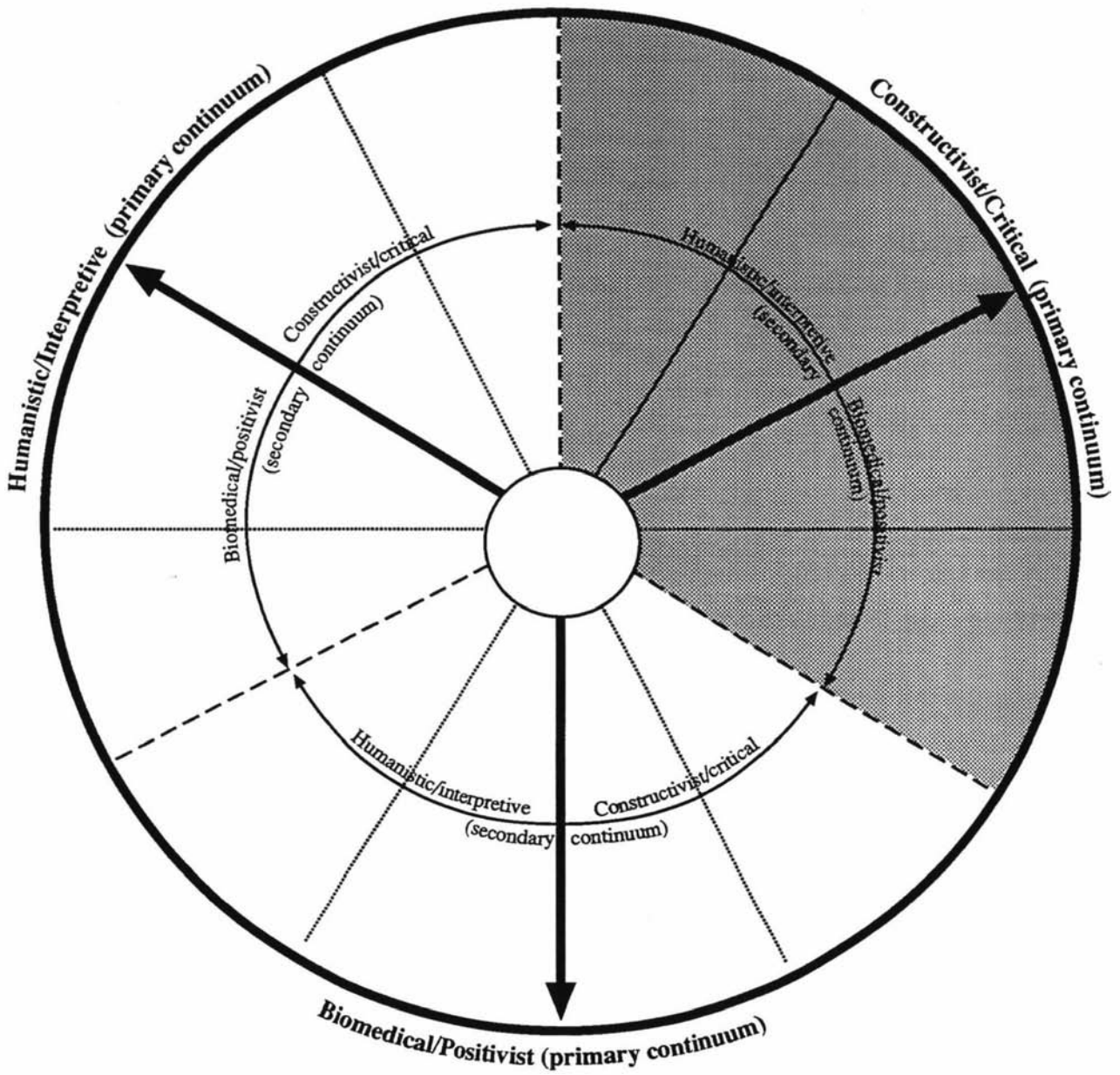
Situations vary widely in terms of the norms governing conduct within them, and participants in any behavioural setting both create and interpret the rules that influence normal conduct within that situation. Recording the situationality of human interaction would be less important if it were not that symbols, meanings, conceptions of self, and actions towards social objects all vary because of the situation.

In short, the focus of a humanistic/interpretive orientation is on explanation and understanding of the meaning of actions, practices and experiences among individuals and groups. The emphasis on representation rather than description fosters the recognition of 'the final representation of the other [as] a fiction in the sense of a document being created out of ongoing dialogue' (Lock and Scheper-Hughes, 1990:49), and indicates a predominantly relativist view of reality - that is, the recognition of phenomena as the product of complex relationships rather than as a series of autonomous, concrete 'facts'. The humanistic/interpretive orientation, however, is limited by its focus on the individual and social group without due regard to the impact of broader social, economic, political and historical factors on human experience.

The humanistic/interpretive orientation (see Figure 2.2), in common with the biomedical/positivist orientation along the humanistic/interpretive side of the primary continuum, employs an empirical methodology. Those studies located along the secondary biomedical/positivist continuum base their understanding and explanation of women's perceptions and experience of menopause on the biomedical model and are influenced by positivist methodology.<sup>4</sup> Characteristic of the approaches located in this vectorial space is their emphasis on description of women's experience which includes documentation of both subjective perceptions and general trends as

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<sup>4</sup> See Beyene (1992), SROW (1988) and Hamilton (1990) as located in Figure 1.2.



**Figure 2.3: Constructivist/critical orientation**

presented, for example, in the SROW (1998) study. Excluded is consideration of the meaning of subjective experience within the context of broader socio-cultural and historical forces.

In contrast, studies located on the secondary constructivist/critical continuum range from a focus on understanding subjective meaning and experience to explanation of the latter within the context of broader social forces and processes.<sup>5</sup> Studies located closest to the primary vectorial continuum focus on the cultural meaning of menopausal experience but exclude critical examination of broader social and theoretical issues relevant to menopause. On the other hand, studies located towards the end of the secondary constructivist/critical continuum recognise a dialectical link between individual perception and action, and the immediate and wider social context. Lock (1982), for example, links individual action and practice with social values and beliefs through identification of the impact of folk (as opposed to biomedical) models underpinning clinical assessment and decision-making among a group of Canadian medical practitioners.

### **Constructivist/critical**

Armstrong (1997:21) points out that the constructivist (a.k.a constructionist) view 'involves a broad church of ideas', strongly but not exclusively influenced by Foucault. From the constructivist perspective all social phenomena are viewed as culturally constructed and the focus is directed at social structures as the products of historical, social and cultural processes (Baum, 1993:9). Knowledge, from this perspective, 'is not simply a given, objective set of facts but a belief system shaped through social and political relations' (Lupton, 1997:99).

Critical theories aim to critique, expose and transform popular recognition of social, political, economic, ethnic and gendered structures as real, natural and immutable. The object is to demonstrate and counteract the constraining, coercive and exploitative nature of social structures on humankind. Accordingly, values are central to critical

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<sup>5</sup> See George (1998), Duncan (1995), Davis (1986), Brown (1982), Buck and Gottlieb (1991), Lock (1982) and Kaufert and Gilbert (1986) as located in Figure 1.2.

methodology which engages the researcher in the role of investigator as well as an instigator, advocate and facilitator for change (Guba and Lincoln, 1994:113-114).

Pulling the constructivist and critical aspects together, the constructivist/critical orientation offers a dynamic, holistic view and understanding of social phenomena and is the position most frequently adopted by feminist researchers. The orientation emphasises the interplay between received wisdom, existing social structures and institutions on the one hand, and on the other hand social, economic and historical processes, and collective human activity. The interactive, contextual emphasis of the orientation blurs the distinction between subject (be it process or phenomena) and observer and so signals a relativist view of reality. The orientation is, however, limited by its exclusion of individual action and experience. Moreover, there is a risk of what Charlesworth et al. (1989:12) identify as ‘pernicious relativism’; that is, the view that knowledge as a socially and culturally constructed event can only have meaning amid the context of the particular circumstances within which it is considered. Such a stance denies the universal or trans-cultural validity of all scientific and medical knowledge because it is viewed as (Charlesworth et al., 1989:13):

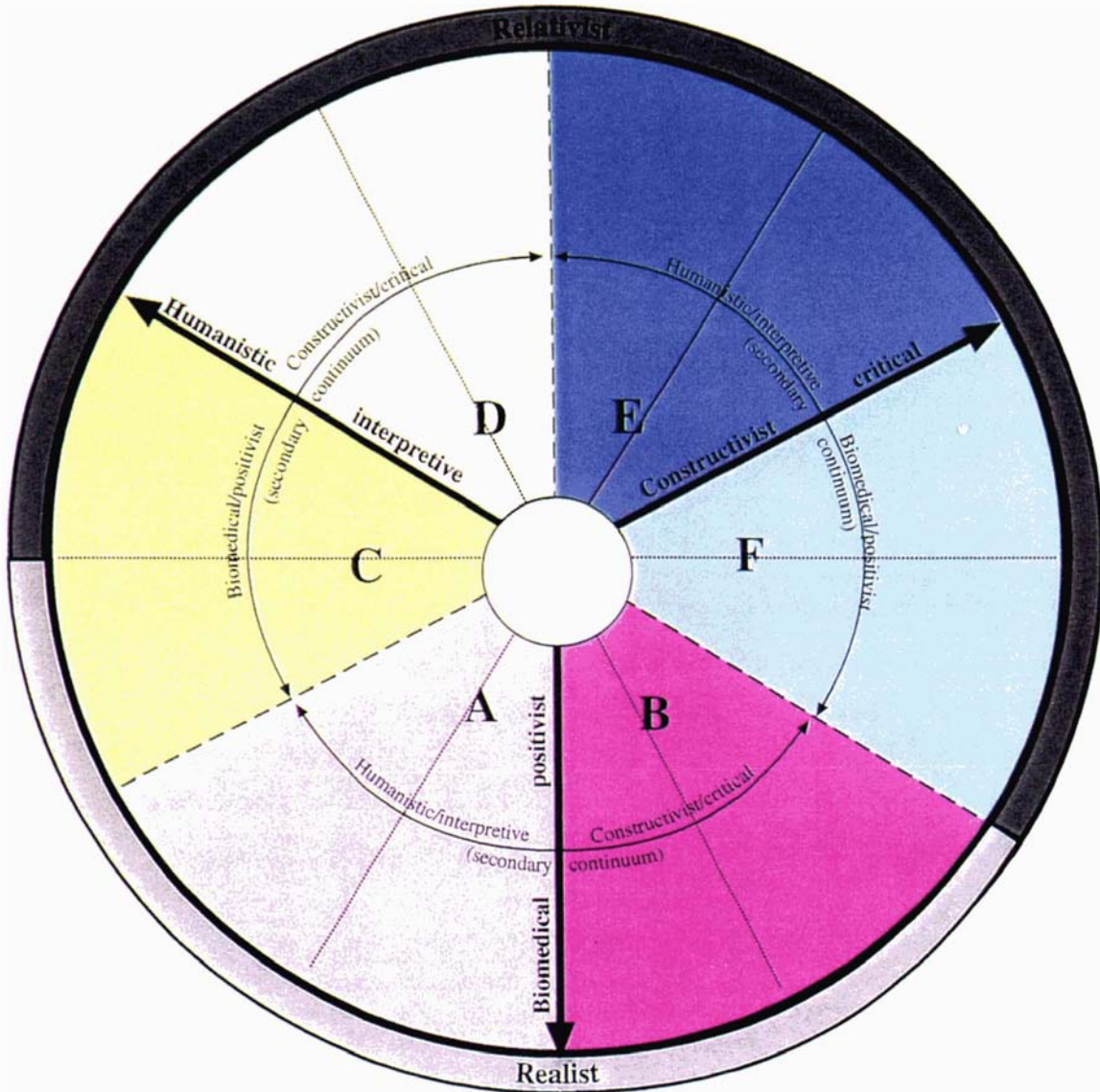
... simply an expression of a particular, Western European culture, just as the use of oracles is an expression of Azande culture, and rain-making rituals are an expression of Australian Aranda culture.

Characteristic of the constructivist/critical orientation (see Figure 2.3), is the focus on menopause as an event shaped and constrained by dominant social, cultural and historical processes. Accordingly, those studies located along the secondary humanistic/interpretive continuum focus on the context from which models of menopause emerge.<sup>6</sup> The aim is to expose menopause as an event shaped and constrained by competing discourses and to explore the social implications of the latter.<sup>7</sup> Estok and O’Toole (1991), for example, examine the social impact of both feminist and medical meanings attached to menopause. In contrast, the critical focus of studies located on the biomedical/positivist side of the primary continuum is

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<sup>6</sup> See Koeske (1982), Duignan (1989), Estok and O’Toole (1991), Flint (1982a), and Griffen (1982) as located in Figure 1.2.

<sup>7</sup> A discourse is a domain of language use, structured as a unity by common purpose (Abercrombie et al., 1984:70).



**Key:**

- A = Biomedical/positivist - Humanistic/interpretive**
- B = Biomedical/positivist - Constructivist/critical**
- C = Humanistic/interpretive - Biomedical/positivist**
- D = Humanistic/interpretive - Constructivist/critical**
- E = Constructivist/critical - Humanistic/interpretive**
- F = Constructivist/critical - Biomedical/positivist**

**Figure 2.4: Realist/relativist paradigms**

limited to the social impact of the medical model of menopause.<sup>8</sup> Coney (1992), for example, argues that the deficiency disease view fosters anxiety and medicalises menopause, whereas Flint's study (1982b), positioned at the extreme end of the secondary biomedical/positivist continuum, employs the biomedical definition of menopause as the standard against which to critique cross-cultural research on the subject. In fact, Flint's orientation overlaps with that employed by Dumble (1992). The difference between the two papers lies with the critical focus of the former on cultural research methodology whereas the latter focuses critically on clinical research methodology.

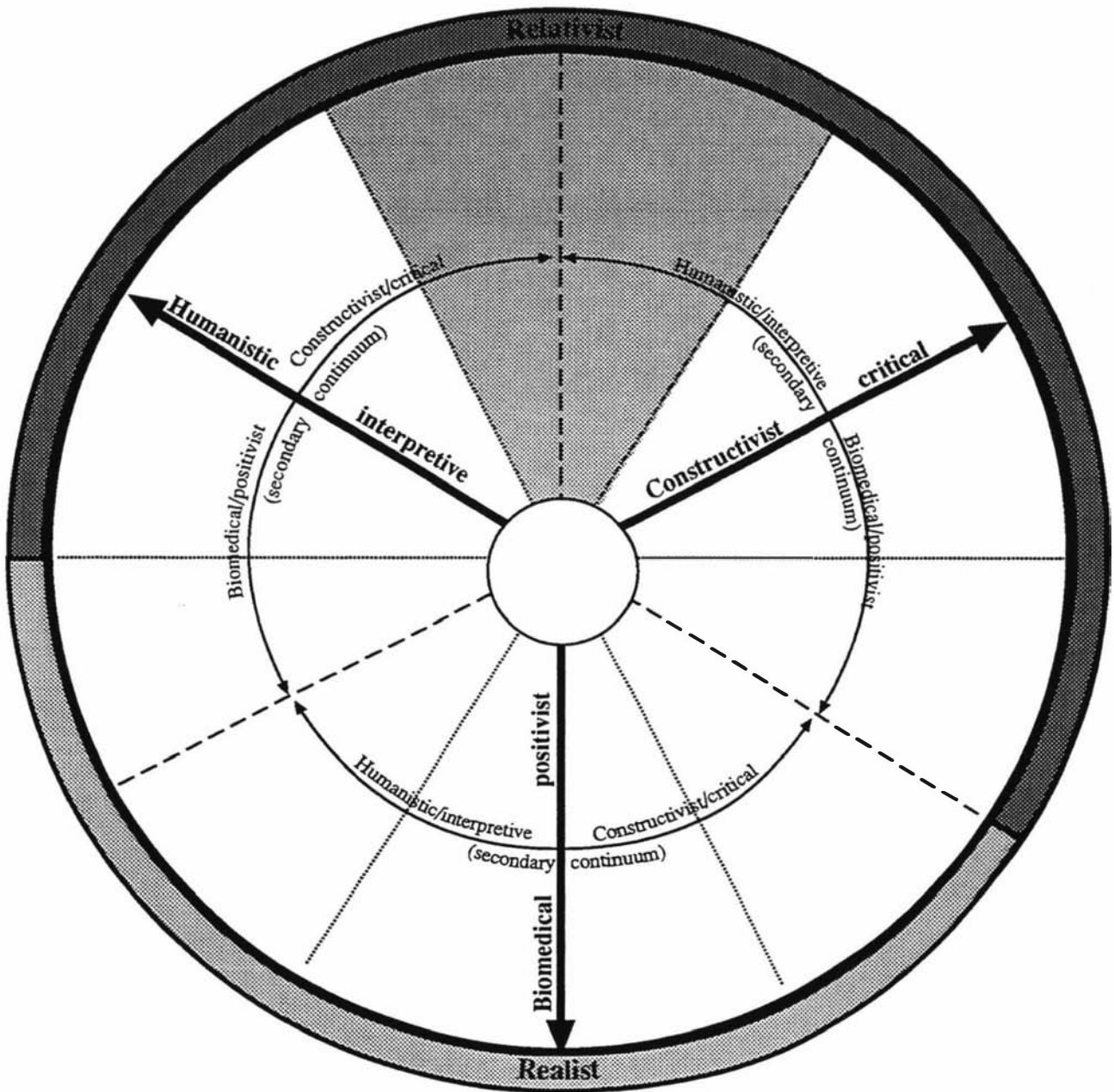
### **TOWARDS A THEORETICAL APPROACH**

Examination of the three theoretical orientations, in terms of their contribution to social research on menopause, illuminates a number of strengths and limitations associated with each perspective. Within each orientation the range of theoretical emphasis and research techniques employed contributes to the blurring of boundaries between the outer segments on each secondary continuum. As a result, the latter represent a theoretical space which avoids the excesses of the 'purer' theoretical forms as represented by the primary continua, while the interface of orientations promises a degree of theoretical flexibility (see Figure 2.4).

Framing the three theoretical orientations are the realist and relativist paradigms (see Figure 2.4). As already indicated, the realist paradigm assumes nature is external to culture and that science describes reality. In contrast, the relativist paradigm views phenomena as the product of complex relationships rather than as a series of autonomous, concrete, unmediated 'facts'. The location of the three theoretical orientations within the framework of the realist and relativist paradigms is asymmetrical. Examination of the areas of intersection of the secondary continua locates the biomedical/positivist-humanistic/interpretive space (segment A) and the biomedical/positivist-constructivist/critical space (segment B) within the realist paradigm (see Figure 2.4, segments A and B). For the purposes of this thesis the realist paradigm is limited by its inability to perceive reality in terms of relations

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<sup>8</sup> Coney (1992), McElmurry and Huddleston (1991), Flint (1982b).



*Figure 2.5: Constructivist/interpretive orientation*

between phenomena or to acknowledge the dynamics of the observational situation. Moreover, the dominance of the assumptions of the medical model of menopause throughout the realist vector offers at best a reductionist, mechanistic understanding of this event.

The relativist paradigm, in contrast, frames the whole of the constructivist/critical orientation (see Figure 2.4, segments E and F) but only three-quarters of the humanistic/interpretive orientation (see Figure 2.4, segments D and C). The fourth quarter of the humanistic/interpretive orientation, located at the interface with the biomedical/positivist orientation, does not conform to the relativist paradigm. The reason is that studies located in this area privilege the assumptions of the realist paradigm. For example, the SROW (1988) study is predominantly a quantitative study, while Beyene (1992) emphasises menopausal experience as hormonally determined. In other words, studies in the fourth quarter of the humanistic-interpretive orientation fail to assert the interactive, contextual character of social phenomena which is characteristic of the relativist paradigm. In contrast, the relativist position of the remaining segments of the humanistic/interpretive orientation and the whole of the constructivist/critical orientation recognises the mediated nature of scientific knowledge and the interactive, contextual character of social phenomena (see Figure 2.4, segments C, D, E and F).

For the purpose of this thesis, the humanistic/interpretive emphasis on explanation and meaning of actions, practices and experiences among individuals and groups complements the constructivist/critical focus on social structures and institutions. The point is that the combined strengths of these two orientations offer the opportunity for insight on women's perceptions and experience of menopause which transcends the boundaries of biomedical/positivist explanations. Represented by the vectorial space on either side of the interface of the humanistic/interpretive and constructivist/critical orientations the theoretical orientation adopted in this thesis is, therefore, a constructivist/interpretive orientation (see Figure 2.5).

To sum up, a constructivist/interpretive orientation facilitates a critical examination of the perceptions and experiences of menopause as a social construct among a group of

New Zealand women. Models of menopause can be recognised as culturally constructed, and normative definitions of the feminine are viewed as crucial to social perception and individual experience of menopause. This constructivist/interpretive orientation informed the design and methodology of this thesis and guided both the analysis and interpretation of data.

### **THE BODY POLITIC<sup>9</sup>**

Haraway (1991:7) identifies the body politic as an ancient concept employed by the Greeks in the form of ‘elaborate organic images for human society...[which] conceived the citizen, the city, and the cosmos to be built according to the same principles’. More recent application of the union of the political and the physiological identifies the body politic concept as the struggle between individual and social desire for control over and of the human body. The body politic has, therefore, the ability to regulate, constrain and shape physical appearance and individual experience of the body. It may even distort human anatomy if the physical body is deemed incompatible with dominant values and practices as, for example, in traditions such as circumcision, body piercing and those targeting body shape such as muscularity and slimness.

In an earlier study where I examined the experience of breastfeeding for four first time mothers, the impact of the body politic emerged as the central aspect of each mother’s experience (Beasley, 1996). Breastfeeding involves both the physical process of lactation and the social practice of suckling and nurturing of an infant. It is a learned behaviour which is profoundly influenced by social beliefs and practices which have the ability to enhance or inhibit milk production. Understanding the experience of breastfeeding requires, therefore, recognition of the body as the site where physical facts meet social values and conflicting and analogous discourses converge. As a result, a common feature of a mother’s breastfeeding experience involves the conversion of her body into a site of conflict and tension generated through the struggle between the physical process of lactation and social requirements of the body politic.

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<sup>9</sup> Much of the material in this section is drawn from Beasley (1998).

In common with breastfeeding, menopause is an event associated with female reproductive functioning which embraces both the physiological and the social mediated through language and culture. Social constructions of menopause are subject to historical change and shift in accord with the different ways the end of female reproductive functioning is articulated and located within a particular context (Jacobus et al., 1990:2). Fundamental to the social construction of menopause are definitions of what is and is not physically and socially normal. As the mechanism responsible for the latter, the body politic is the central instrument of control of the menopausal body and so shapes and constrains women's expectations, perceptions, experience and practices associated with this event.

### **BIOMEDICAL HEGEMONY AND MEDICALISATION**

Underpinning the body politic's ability to control the menopausal body are the processes of biomedical hegemony and medicalisation. The concept of hegemony was originally developed by Gramsci, the Italian Marxist, in response to the ability of power exercised by the ruling class over the state to infiltrate and eventually dominate civil society. Accordingly, hegemony can be defined as the internalisation of the beliefs and values of a dominant group to the extent that they become unconsciously accepted as the normal, correct and/or common sense view. The relevance of hegemony to this discussion lies within its ability to constrain individual perception and definition of the body and appropriate corporeal practice. Hegemony manifests itself within the human frame where it is apparent in a variety of tangible, historically locatable, manipulations of body physique and individual action. As a significant force in shaping individual perception and defining the body and appropriate individual practice, hegemony is manifest within the socially correct body and accompanying practice and action. Biomedical hegemony can be defined, therefore, as the internalisation of the medical view of physical functioning, health and illness to the extent that it is unconsciously accepted as the 'natural' and common sense view. In the case of menopause, biomedical hegemony is apparent in popular acceptance and articulation of this event as a state of hormonal change and decline.

It is clear that biomedicine, as a hegemonic influence, consciously and unconsciously affects the way we view our bodies, health and disease. Integral to biomedical

hegemony, however, is the notion of 'medicalisation'. Originally defined by Illich (1976) as a process of control over resources, the term medicalisation has been broadened to accommodate recognition of the cultural nature of biomedicine.<sup>10</sup> In common with all medical systems, biomedicine presents a sense of the world that reflects and buttresses the existing social order, making it necessary to understand the process of medicalisation as one involving both hegemonic influences and control of access to resources.

Redefinition of physical functioning, health and illness through medicalisation, transforms many everyday phenomena such as menopause into processes dependent on medical expertise and intervention. As a result, processes previously recognised as falling within a range of 'normal' are redefined as pathological. Knowledge of the body and its functions is transferred from individuals and groups to health professionals who become recognised as the acknowledged experts. Associated with the latter is the devaluation of lay knowledge and skills and the emergence of a specialised vocabulary which (as it becomes incorporated into the vernacular) reconstructs and mystifies popular conceptions of particular events (Van Esterik, 1989:115). The significance of the process of medicalisation for menopause lies with the ability of medical science to redefine a normal stage in the female life cycle as a disease of hormone deficiency akin to diabetes or thyroid dysfunction and to prescribe treatment with the full force of expert authority that is recognised and accepted.

## **COMMON SENSE, AGENCY AND EXPERIENCE**

### **Common Sense**

As indicated above, an integral aspect of both hegemony and the process of medicalisation is the internalisation of dominant ideologies to the extent they become unconsciously accepted as the normal, 'natural' and common sense view of reality. Schutz (1967, cited in Hall, 1978:20) identifies the realm of everyday life as the most 'sedimented region of reality and of consciousness', a realm where the most appropriate mode of consciousness was the most taken-for-granted of all the modes - the domain of common sense. He also notes that because common sense embraces the

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<sup>10</sup> See Bell (1987), and Lock (1988).

seemingly 'normal' and 'natural' reality of everyday life, the constructed nature of its meanings are taken-for-granted and go largely unrecognised and unchallenged.

Gramsci (1971, cited in Hall et al., 1978: 49-50) points out that common sense is inherently disjointed and eclectic. Because it is not systematic and fails to make its mode of reasoning explicit it is able to combine contradictory ideas without being aware of the fact. The outcome is the creation of a 'storehouse' of knowledges drawn from antecedent ideologies and a variety of social classes. In particular, common sense is characterised by the absence of a 'consciousness of historicity' which condemns it to a position of subordination and dependence in relation to other realms of thought or knowledge sources. According to Hall et al. (1978:50) 'popular notions such as 'human nature' effectively discount the possibility of change and 'naturalise' the social order'. It was the 'naturalisation' process that Gramsci perceived as a key mechanism of common sense thought.

Although there is no fixed hierarchical relationship between the dominant ideology and common sense, it is clear that hegemonic processes such as medicalisation can impact on popular thought or common sense views of reality. This may occur either through the introduction of new perceptions of reality and/or the reconceptualisation of existing perceptions of reality (such as popular explanation of menopause in terms of hormonal activity) or perhaps by setting boundaries on the development of common sense knowledge (as, for example, through medical reconstruction and accompanying mystification of physiological events). Common sense, in other words, is generally fluid or subject to change in one way or another over time.

As a mode of consciousness and a 'storehouse of knowledges', common sense is recognised as having a significant role in everyday life. Bearing in mind its eclectic, disjointed and contradictory qualities, the role of common sense in relation to menopause is multi-dimensional: it defines an everyday female life event; it shapes expectations and gives social meanings to this event; it explains the event and associated phenomena; and it shapes responses to this event. However, the impact of common sense will vary in relation to popular acceptance of competing knowledge sources and the particular socio-historical context.

## Agency

The notion of the individual as an agent involves the recognition of a coherent inner self that has the ability to determine those practices, actions and strategies deemed most meaningful and/or appropriate.<sup>11</sup> An integral aspect of agency is the power of the individual to make a difference to their life or to have acted otherwise. Citing the example of the very ill patient who is disruptive or resistant to treatment procedures, Pappas (1990:200) argues that ‘even the most seemingly ‘powerless’ individuals are able to mobilize some types of resources which give them control over their day-to-day lives or the lives of others’. His point that ‘actors in subordinate positions are never wholly dependent’ is of particular relevance to this thesis and emerges through the ability of women to resist, reconstruct, juxtapose or accept models of menopause commensurate with individual views and circumstances.

## Experience

Linking agency with experience, Lyon and Barbalet (1994:54) note:

...the human capacity for social agency, to collectively and individually contribute to the making of the social world, comes precisely from a person’s lived experience of embodiment.

As the central aspect of human existence, experience encompasses not only observed actions and practices but ‘conventional patterns of culturally learned and interpreted behaviour that makes them understandable to others’ (Abrahams, 1986: 49). Experience embraces both the ordinary and the everyday and the extraordinary and eventful, and because of the meanings and feelings it embodies and the responses it evokes becomes the individual’s own ‘storehouse’ of knowledge. Abrahams (1986:49) identifies experience as:

...a term of connections because it encourages us to discuss life in terms of how present activities...may be drawn on and replayed in some form in the future: ‘Experience is the best teacher,’ ‘Live and learn,’ and all that.

The notion of experience as the teacher and a knowledge source is employed throughout this thesis. Not only is experience fundamental to common sense views or knowledge of menopause among women but it also plays an important role in the

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<sup>11</sup> The concept of agency is surrounded by a vast area of theoretical debate which is outside the scope of this thesis. See, for example, Haraway (1991).

formation of the clinical views and practice strategies employed by medical practitioners.

## **STUDY METHODOLOGY**

The rejection of realist explanations of reality in favour of the relativist view commensurate with a constructivist/interpretive orientation, signals the employment of an ethnographic research methodology for this study. An ethnographic approach portrays 'people as constructing the social world, both through their interpretations of it and through actions based on those interpretations' and so is ideally suited to the study's aim of understanding and explaining the experience of menopause within the context of wider socio-historical factors (Hammersley and Atkinson, 1995:11). Fundamental to an ethnographic approach is researcher engagement with the research population through a range of techniques, including focus groups and in-depth interviews, both of which were used in this study and are described in later pages of this chapter.

### **Ethics**

Prior to the commencement of the study, ethics approval was sought and obtained from the Massey University Human Ethics Committee.<sup>12</sup> Details of intended recruitment procedures, the process for securing informed consent, interviewing strategies and the processing and ownership of information and material obtained from the study were outlined. In addition, strategies for ensuring confidentiality (particularly within the focus group situation), the right to decline to participate in or withdraw from the study, the right to have particular information deleted or withheld or the tape-recorder turned off during an interview, and the right to be referred to by a given name if so desired, were also detailed. Copies of all information sheets and consent forms used with the participants were submitted and approved as part of the application. All procedures detailed in the application have been adopted and adhered to throughout the study.

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<sup>12</sup> See Appendix 1.

### **Research Sites - Local and National**

The central site for the study was the town of Feilding and the surrounding rural areas of the Manawatu district. Constituted as a borough in 1881, Feilding was named after Colonel Hon. William Adelbert Feilding, the chief administrator of the Immigrants and Colonists Aid Corporation, who purchased 106,000 acres (42,898 hectares) in 1871 (Target Marketing Ltd., 1995:16). Situated about fifteen kilometres north-west from Palmerston North, in the North Island of New Zealand, Feilding is a fairly typical rural town with a population of just over 14,000 at the time of the 1996 Census (Statistics New Zealand, 1997a). Its proximity to Palmerston North identifies it as a commuter 'suburb' for the city but it is also a popular retirement area for the district's farmers (11.8 per cent of the borough's population was aged sixty and over) and a pastoral and agricultural service centre for an area renowned for its stock breeding. Formerly dominated by the now closed Borthwicks freezing works, Feilding has traditionally been a blue collar town and in common with most provincial settlements is currently affected by a lack of employment opportunities (almost 8 per cent of those in the labour force identified themselves as unemployed in 1996). It should, however, be noted that 42 per cent of Feilding's population had no educational qualifications (Statistics New Zealand, 1997a). As the central research site, Feilding and the surrounding districts offered two advantages: first, easy access to a geographically defined community comprising both provincial town and rural women; and second, a population that has not been repeatedly exposed to the research activities of a university city such as Palmerston North.

Feilding boasts a number of distinctive features. It is a site of national stock sales which are conducted in yards adjacent to the main shopping area. The central business area itself is characterised by a lack of parking meters and a relaxed, friendly atmosphere. As a regular winner of the 'beautiful towns' award, Feilding is well known for its colourful, well groomed domestic gardens and attractive central squares and park areas.<sup>13</sup> In addition to a number of public amenities such as the Makino swimming pool complex, library and race course, Feilding is also the site of the Manfield

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<sup>13</sup> Feilding again received 'the most beautiful town award' for 1998, which it has won for eight of the last ten years, being runner-up in the remaining two.

Autocourse, a national motor racing facility. The town supports an impressive number of active social organisations and clubs with over two hundred and thirty-eight listed in 1995 (Target Marketing Ltd., 1995:20-23).

The surrounding rural areas of the Manawatu district (253,164 hectares) extend from Rangiwahia in the north to Himatangi in the south.<sup>14</sup> The western boundary is the Rangitikei river and the eastern boundary the Ruahine ranges, Palmeston North City and the Manawatu river. In 1996 its total population was 28,077 of whom 14.7 per cent were aged sixty and over, a proportion slightly below the national average of 15.4 per cent (Statistics New Zealand, 1997a). The majority aged fifteen and over were employed in agriculture which encompasses the district's dairy, sheep and cattle farms, stock breeding, cropping, horticulture and forestry. Unemployment was relatively low in 1996 at 6.1 per cent when compared with almost 8 per cent for Feilding and 7.7 per cent for New Zealand as a whole (Statistics New Zealand, 1997a). Like Feilding, however, a high proportion of those aged fifteen and over reported they had no formal qualifications - 40.4 per cent, which was above the national average of 34.7 per cent (Statistics New Zealand, 1997a). As one would expect of a rural population with predominantly owner-operated family farms, 75 per cent of all households were one family households.

In addition to the prime site, participants were recruited throughout the country with an advertisement placed in the *New Zealand Woman's Day (NZWD)*, a national women's magazine. The rationale for the inclusion of the *NZWD* readers was to establish whether or not women in other parts of the country shared views and experiences similar to those of participants in Feilding and the Manawatu district. Finally, a number of local general practitioners and New Zealand Family Planning Association (NZFPA) menopause educators were also interviewed. The objective here was to obtain views on menopause and its management from a group of health professionals who were in a position to influence women's experiences of this event.

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<sup>14</sup> The Maori names of these two settlements are interesting. Rangiwahia means 'an opening in the heavens, or cloud piercer' and Himatangi is a combination of 'Hi, to fish with hookline, and Matangi the name of a chief' (Target Marketing Ltd., 1995:16).

Details of the recruitment process and interviewing techniques for all three groups are discussed below.

### **The Participants/Respondents**

For the purposes of this study the population of interest was defined as women aged thirty years and upwards, in order to capture the experience of menopause in different age groups and to make comparisons across the age groups. The lower age limit of thirty was set on the assumption that women under thirty were likely to feel that menopause was of little relevance to their current life-stage, had given the matter little or no thought and would be uninterested in the study.

The strategies for recruitment involved three techniques of non-probability sampling. The first two, judgement and opportunistic sampling, require the researcher to be well informed with respect to the site from which suitable respondents can be drawn. Judgement sampling entails the selection of respondents on the basis of the researcher's judgement about which ones will be the most useful or representative. Opportunistic sampling, on the other hand, involves the recruitment of qualified informants as they become available. Such informants must be able and willing to provide specific data, as in the case of the general practitioners and menopause educators (see below). The third strategy, snowball sampling, occurs when respondents are recruited through referrals from informants already involved in the study. Accordingly, snowball sampling 'follows the pattern of social relations in a particular setting and therefore the population in the sample involves individuals *and* relations among individuals (Burgess, 1993:55).

### ***The Women***

The data collection process commenced in mid-1995, when letters were sent to the presidents of sixteen women's social organisations in Feilding informing them of the study and requesting:<sup>15</sup>

...that your committee bring the research project to the attention of your members through distribution of the enclosed information sheets...[and] if you could provide me

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<sup>15</sup> See Appendix 2.

with a list of names and telephone numbers of women who would be willing to be contacted about possible involvement in the project.<sup>16</sup>

In compliance with ethical procedures, the confidentiality of names forwarded by the organisation was assured and it was emphasised that an indication of interest carried no obligation to participate in the study. In addition to the recruitment of respondents, the strategy of contacting the women's social organisations aimed to effectively reach a large group of people, draw attention to the project and encourage the participation of women across a range of sectors of the community.

As a recruitment strategy, respondent contact through local social organisations was not without its problems. In several cases, for example, an ageing membership meant an organisation had gone into recess, while in others the members reacted ambivalently or negatively to the research topic. Typical of the latter were comments such as 'not interested', 'past that stage and had forgotten', or 'not much to tell'. In addition, several organisations distributed a good number of information sheets among members with little or no result. In one case I received an apologetic phone call from the president of a sewing club who was concerned that the manner in which she had 'presented the matter' to the meeting may have affected the outcome. She explained the reaction of embarrassed laughter in response to my letter and a general feeling that menopause was outside the concern of the club. Over coffee at the end of the meeting, however, some of the women started discussing menopause 'and some hairy stories were told'. As a result, a number of women expressed interest in being involved in the study and took part in the first focus group meeting. Although fewer participants than expected were recruited through local social organisations, the strategy was successful in initiating the snowball process of recruitment.

The women's reactions to the request for involvement in the study came as a surprise and appeared to reflect a number of factors. For example, my diary notes that Mrs. B. (the contact for a social, a dancing and a horticultural organisation) telephoned to say:

...she [had] advised [the social and horticultural associations, but they were] not interested. [The women] either felt they had got through this stage and had forgotten (or wanted to forget) or didn't have much to tell as they only had a few problems. [The women] seemed to be very reluctant to discuss the matter and there was a feeling it was

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<sup>16</sup> See Appendix 1.

not a concern of either group. Mainly older women [members]. Some of the dancing members were interested and took information sheets and will probably contact me.

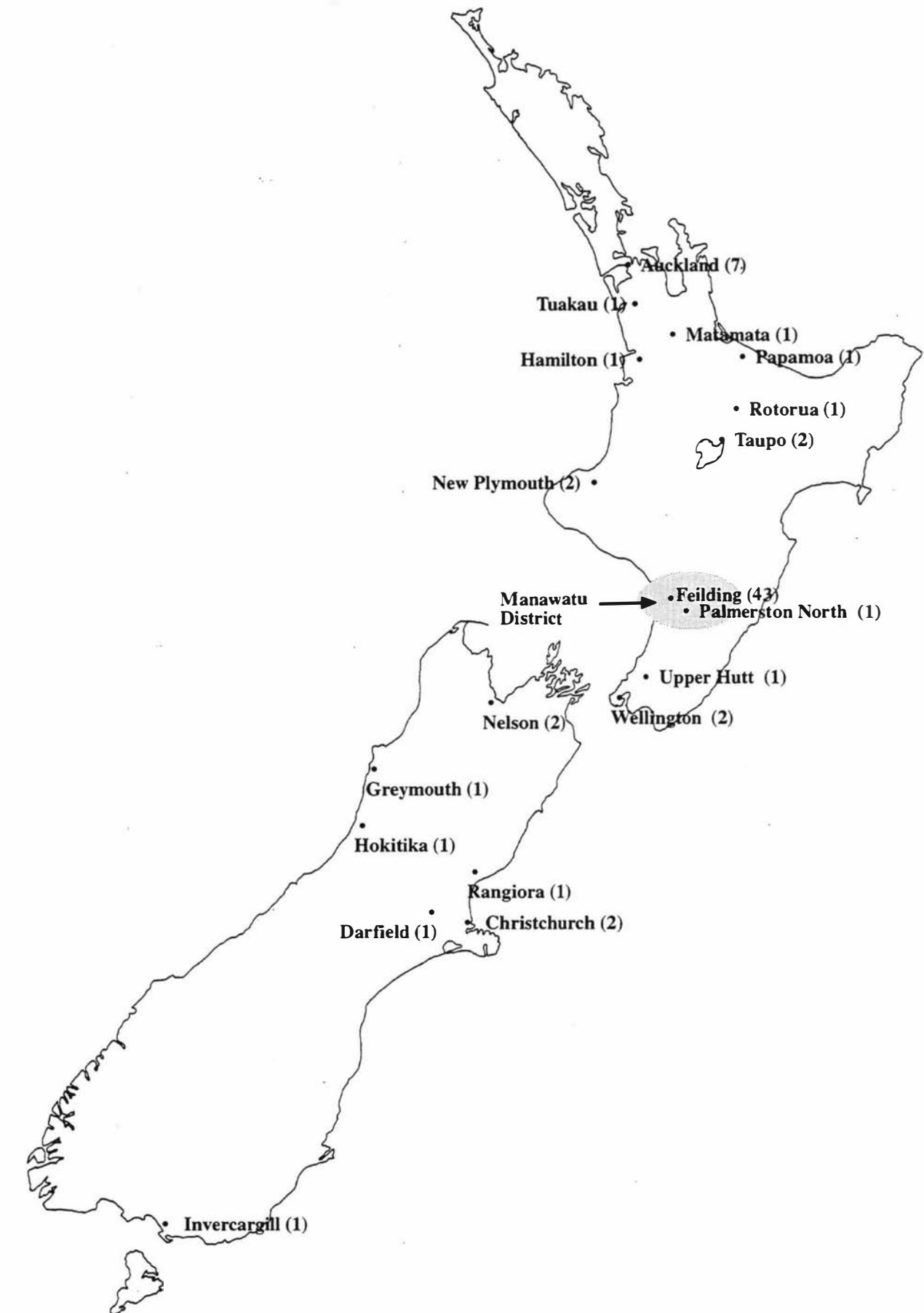
A number of possibilities underlie the reluctance to discuss or even remember the experience of menopause. These include an uneventful experience, a reluctance to discuss anything related to female reproductive functioning, shyness, stoic acceptance of such events as a woman's lot in life, and perhaps a fear of appearing ignorant and uninformed on such matters. Moreover, as indicated by my field notes and suggested by the sewing club president, many appeared to feel it was outside the concern of the social group they belonged to. Such comments suggest that some of these women compartmentalised their lives, with aspects such as menopause belonging to the realm of the private and personal. They also signal that menopause was not an event routinely discussed among women, at least in the public sphere, and this may well have accounted for some of the reluctance to be involved in the study.

In all, fourteen women from the social organisations contacted participated in the study and a further twenty-nine were contacted through the process of snowballing. A total of forty-three women from Feilding and the Manawatu district were recruited for the study, fifteen of whom participated in both focus group and individual interviews. These women are identified throughout the study with an asterisk (for example, Marion\* and Judy\*) in order to distinguish them from the nationwide pool of *New Zealand Woman's Day* respondents.

In common with the Feilding and Manawatu district respondents, the *New Zealand Women's Day* (NZWD) readers were a self-selected group who responded to publicity about the study. The following letter was published in the 8 January, 1996 issue of the magazine's regular feature 'Your Helpline'.

#### **MENOPAUSE RESEARCH**

I am a social anthropologist researching women's experience, knowledge and attitudes towards menopause, and would like to hear from women aged 30 onwards about their views. Anonymity guaranteed. For an information sheet, please contact: Annette Beasley, Department of Social Anthropology, Massey University, Private Bag 11222, Palmerston North; phone (06) 350 4911.



*Figure 2.6 Geographical distribution of study participants in New Zealand*

Forty-seven requests for information sheets were made in response to the letter and thirty narratives were subsequently received from women living as far apart as Auckland and Invercargill.<sup>17</sup> Each narrative was acknowledged with a thank you letter which sometimes included a request for further information.<sup>18</sup> In all cases the women responded to the request and several even telephoned to check the adequacy of their replies.

Demographic details were collected from both the in-depth interview and *NZWD* respondents.<sup>19</sup> In the case of the focus group participants, the only details recorded were those of age and residential location. One third of the Feilding women who participated in in-depth interviews had lived in the Feilding-Manawatu district for all or most of their lives, a further third had resided in the area for more than twenty years and only one for less than ten years. Details on ethnicity were collected only from the in-depth interview respondents, with twenty of the twenty-seven identifying themselves as New Zealanders. Among the remaining seven, one was American, two classified themselves as European and the remaining three prefaced their ethnic origin with the term 'pakeha'. (i.e. pakeha New Zealander, pakeha American, and pakeha English). The rejection of the 'pakeha' identity of by the majority of the women can be accounted for in two ways: first, it is frequently considered a derogatory term by New Zealanders of European origin; and second, although commonly used to refer to all non-Maori New Zealand citizens, it is widely associated with political correctness.<sup>20</sup>

Many of the in-depth interview participants indicated discomfort and even surprise at being asked to classify their ethnic identity and I found myself apologising for the question. The women's reaction appeared to reflect the fact that 85 per cent were New Zealand-born and had already given their birthplace. As a result, when asked to specify their ethnic identity, many conveyed almost a sense of offence at the suggestion that they would consider themselves anything other than a New Zealander. In view of the

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<sup>17</sup> See Figure 2.6.

<sup>18</sup> One response was not suitable for inclusion in the study and has not been included Table 2.1 detailing the characteristics of the study respondents.

<sup>19</sup> See Appendix 3 and Appendix 4.

<sup>20</sup> The original meaning of 'pakeha' was 'white dogs'.

sensitive nature of the question, and given that it was not a central issue in the study, the *NZWD* respondents were not asked this question.<sup>21</sup>

A summary of the participant's characteristics (Table 2.1) identifies the majority of the women as residents of provincial New Zealand. Similarities are evident between the educational levels of the in-depth interview and *NZWD* groups. For example, 48 per cent in each group had achieved an educational level higher than School Certificate.<sup>22</sup> On the other hand, differences emerged between the two groups with respect to occupational categories. Only 7 per cent of the *NZWD* participants classified themselves as housewives in contrast to 33 per cent of the in-depth interview group. Moreover, 35 per cent of the *NZWD* respondents were engaged in administrative or secretarial work compared to 4 per cent of the in-depth interview women. Overall, the women's social and demographic characteristics indicate a heterogeneous population rather than one drawn from a particular socio-economic group.

The higher number of in-depth interview women who classified themselves as housewives can be accounted for in two ways. First, nearly 30 per cent of these women were over sixty years of age compared with 7 per cent of the *NZWD* respondents. Second, very few of the farming women were in paid employment with most being involved on the farm although not all classified themselves as farmers. In contrast, the much larger number of *NZWD* respondents employed in administrative/secretarial positions may have reflected the fact that the majority of these women were from urban or larger provincial centres where there are more employment opportunities for women with these skills.<sup>23</sup>

Finally, there were differences between the groups in terms of the partner's occupation and the ages of the participants. As one would expect in a rural area, a greater

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<sup>21</sup> There is a prevailing view that it is culturally inappropriate for a New Zealander of European origin to engage in researching Maori experience. As a consequence I did not deliberately seek or exclude any women on the basis of ethnicity, nor did the study intend to employ ethnicity as a framework for investigation of women's views and experience of menopause.

<sup>22</sup> School Certificate is the first national examination sat by senior pupils, usually around the age of fifteen years.

<sup>23</sup> The *NZWD* women employed in administrative/secretarial positions were from Auckland (4), Christchurch (1), Nelson (2), Tuakau (1) and Hokitika (1).

percentage of the Feilding-Manawatu women were married to farmers. On the other hand, a higher proportion of the *NZWD* partners were employed as agricultural workers or in semi- or unskilled occupations, and there was a higher proportion of cases where no details of a partner's employment were provided.<sup>24</sup> Finally, the focus and in-depth interview groups were reasonably similar in terms of their age group distribution (especially for ages 40-69), whereas the *NZWD* group was heavily concentrated in the 40-49 and 50-59 age groups. While it is difficult to account for this difference (as it may in part be due to the nature of the *NZWD* readership population) it seems possible that younger women among the *NZWD* readers felt that menopause was of little relevance in their lives and accordingly didn't bother to respond to the published notice concerning the study. In contrast, older women, like those from the Feilding social organisations, may have been reluctant to discuss the subject or felt they had nothing to say.

Overall, the main feature to emerge from Table 2.1 is that of heterogeneity, with differences between and within the three groups that have important implications for this study. Differences in education and occupation, for example, have implications with regard to lifestyle, access to resources and a woman's confidence in her own knowledge and/or ability to seek out knowledge or to question the information and advice offered by health professionals. Similarly, age or generational differences have a bearing on: personal attitudes, values and beliefs; relationships with family members, friends and workmates; marital experience and status; and individual health and well-being. The point is that each of the participants is uniquely situated, and their experience of menopause is the product of a complex set of social and physiological factors - only a few of which are explored in any detail in this study.

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<sup>24</sup> The comments of these women signalled that they were single.

**Table 2.1 Characteristics of study participants (percentages)**

	<b>Focus Groups N=16<sup>25</sup></b>	<b>In-depth Interviews N=27</b>	<b>NZWD readers N=29</b>
<b>Residence</b>			
rural	12.5	33	nil
provincial	87.5	67	59
urban	nil	nil	41
<b>Education</b>			
without School Certificate	n/a	30	24
with School Certificate	n/a	22	28
above School Certificate	n/a	48	48
<b>Occupation</b>			
housewife	n/a	33	7
retired	n/a	15	10
commercial/service <sup>26</sup>	n/a	18.5	28
farmer		11	nil
administrative/secretarial	n/a	4	35
professional <sup>27</sup>	n/a	18.5	17
no information		nil	3
<b>Partner's occupation<sup>28</sup></b>			
professional/managerial	n/a	15	14
clerical/service	n/a	7	7
self employed/trade	n/a	33	41
farmer	n/a	30	3
agricultural worker, semi-skilled/unskilled	n/a	7	21
unemployed	n/a	4	nil
no information	n/a	4	14
<b>Age</b>			
age 70+	nil	11	3.5
age 60-69	19	18.5	3.5
age 50-59	25	22	45
age 40-49	31	30	48
age 30-39	25	18.5	nil

<sup>25</sup> Aside from age and residential location, demographic details were not collected from focus group participants.

<sup>26</sup> Commercial/service includes those women who were self-employed in addition to those in semi-or unskilled occupations such as clothing manufacture, food preparation, shop assistants and factory work.

<sup>27</sup> The majority of the women in this category were employed as teachers or nurses. In addition there was a social worker, journalist and laboratory technologist.

<sup>28</sup> The occupation of a retired or deceased partner is included.

### *Medical Practitioners*

A letter detailing the nature and scope of the project was sent to all Feilding general practitioners listed in the telephone book. The letter requested:

...the opportunity to conduct a taped interview....The focus...would be on the practitioner view of menopause, treatment of difficulties, type of information available to women through practitioners, and an overview of the types of enquiries, knowledge and expectations held by women who seek consultation.

Respect for the practitioner's obligation to patient confidentiality and confidentiality of information obtained was emphasised.<sup>29</sup> The letter was followed up with a telephone call to each doctor's surgery to arrange an interview appointment. The response was disappointing with only two of the ten doctors consenting to be interviewed. In all cases the receptionist would not allow direct contact with the doctor who generally left a message declining to be involved on the grounds of being too busy. The two Feilding doctors who did agree to participate in the study were both partners in different family group practices. Because of time restrictions both consented to be interviewed in their lunch hour.

The older of the two Feilding practitioners interviewed was in his early fifties and had been practising in the area for around twenty years. He told me he had consented to an interview only after pressure from his wife, a Massey University student, who felt I 'deserved to be given a chance'. The interview took place in his surgery office and he was friendly and forthcoming with his replies to my questions. The younger practitioner was in his mid-thirties and we met in the Practice staff room while he ate lunch. My field notes record that he was 'very pleasant and obviously enjoyed [the interview]. [He] would have continued [with the interview] had it not been for patients waiting [for consultation]'. At the end of the interview he instructed the receptionist to give me a sample of the pamphlets on menopause routinely handed out to patients.

In light of the low response rate among the Feilding doctors, and the fact that the focus groups revealed that Feilding women frequently travel to Palmerston North to seek medical consultation, a decision was made to interview selected Palmerston North practitioners. Five doctors from a group practice and one independent practitioner

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<sup>29</sup> See Appendix 5.

were contacted through personal channels and agreed to participate in the study. The group practice doctors comprised three men and two women. The three men and one of the women had a family patient base, while the other woman, a younger practitioner in her early thirties, had a predominantly female patient base. The independent practitioner worked part-time in several practices, including one located in a country town and another at a women's health clinic where the interview took place.

In addition to the general practitioners, contact was also made with a specialist consultant, who although consenting to be interviewed required payment of the standard hourly fee for her time. In light of this experience and the disinterest displayed by another specialist consultant when I informed him of the proposed study, further efforts to contact this group of health professionals were abandoned as futile. The point that needs to be made here, however, is that the recruitment difficulties experienced signal the ability of doctors to act as knowledge gatekeepers, in this case through charging for research time or denying researcher access.

As an alternative to face-to-face interviews, the views of five specialist consultants were obtained from the transcripts of two educational audio tapes.<sup>30</sup> However, use of such information raises several issues. For example, their comments are shaped by the requirement of targeting a specific audience via a specific pre-determined framework. Not surprisingly, there is a lack of opportunity for the spontaneity and subjective input characteristic of the unstructured interview. Moreover, as acknowledged experts providing public information, the specialists' professional credibility emerges through their emphasis on scientifically verifiable, medically validated knowledge and through references to their professional and clinical experience. As a result, in contrast with the general practitioners, it was impossible to establish the impact of personal and social factors on their views concerning menopause.

### ***New Zealand Family Planning Educators***

The participants, all women, were contacted through the New Zealand Family Planning

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<sup>30</sup> These tapes were produced by a pharmaceutical company and the New Zealand national broadcasting network, respectively. See Chapter 4.

Association. They included the current, but recently appointed Palmerston North branch educator (who also served Feilding and the outlying rural area), the North Island Education Co-ordinator based in Wellington, and a former (Palmerston North) part-time educator. The newly appointed, Palmerston North educator, although very willing to participate and help in any way, felt that she was not in a position to be able to discuss the organisation's philosophy or provide details on the nature of its menopause education programmes. At her suggestion, I contacted the North Island co-ordinator's office in Wellington and an interview appointment was arranged. This interview lasted over two hours, during which time the co-ordinator took great care to detail both the philosophy and activities of the organisation and to answer any of my queries. At the end of the interview she introduced me to the area staff and provided samples of the printed educational material offered to women seeking information on menopause. The former Palmerston North educator, who had been active in menopause education about seven years earlier, was interviewed in her home.

### **Data Sources and Collection Techniques**

The data used in the study was drawn from six sources: the literature review; menopause education videos and audio-tapes; a content analysis of menopause education material; focus group interviews; in-depth interviews; and respondent narratives. In addition to providing a template for the identification of a theoretical orientation for this thesis, the literature on menopause presented a valuable background on current attitudes, perceptions, beliefs and management strategies from which to launch the study.

### ***Menopause Education Material***

The menopause educational material ranged from pamphlets and booklets to video and audio-tape material, much of which was produced by pharmaceutical companies and distributed through medical practitioners or women's health clinics.

### ***Content Analysis***

The second source of data involved a content analysis of three menopause workshops and a selection of educational video, audio-tape and printed material as follows:

- Workshops: i) Australasian Menopause Society, *Management of Menopause and Beyond*, public meeting, Concert Chamber, Wellington Town Hall, 21 February 1996; ii) Women's Health Action, *Menopause and HRT*, Women's Health Action Trust, Gillies Avenue, Auckland, 7 May 1994; and iii) New Zealand Family Planning Association, *Menopause Workshop*, New Zealand Family Planning Association Clinic, King Street, Palmerston North, 17 May 1996.
- Videotapes: i) Novo Nordisk Pharmaceuticals Ltd. 1994: *A Change for the Better: Menopause and HRT Explained*, Auckland; and ii) Ciba-Giegy (NZ) Ltd, n.d. *Change of Life*, Sydney.
- Audio-tapes: i) Wyeth Pharmaceuticals Pty. Ltd, 1992: *Presenting a Positive Outlook on the Menopause*, Drivetime Radio Productions Pty. Ltd, Sydney; and ii) Replay Radio, 1982: *Menopause: A Period of Change for Women*, produced by Gillian Woodward, Radio New Zealand, Wellington.
- Booklets: i) Novo Nordisk Pharmaceuticals Ltd., n.d., *Voices of the Menopause*, Auckland; ii) Ciba-Giegy (NZ) Ltd., n.d., *Living Through Change: Information for Women About the Menopause*, Auckland; iii) Radio New Zealand, 1988: *Menopause: A Period of Change for Women*, Wellington; iv) 3M Pharmaceuticals, n.d., *Understanding the Menopause*, Auckland; and v) Department of Health, 1991: *Menopause*, Department of Health, Wellington.

The purpose of the content analysis was to explore the representations of menopause promoted through educational material that was readily accessible to New Zealand women. As a social research strategy, the focus of any content analysis is on artefacts associated with human communication (Babbie, 1992: 312-313). Methodologically, a content analysis involves the quantification, coding and/or classification of data within a conceptual framework for the purpose of identifying the manifest or surface content and/or the latent or underlying meaning of particular artefacts. The technique and procedure for content analysis is presented in the next section of this chapter.

### ***Focus Groups***

In contrast with the literature review and content analysis, the three remaining data sources involved respondent contact through different interview techniques. The first

was a series of focus group interviews. Thomas et al. (1992:7) describe a focus group as:

...a discussion amongst a small group of people including a moderator or facilitator. The facilitator usually introduces the topics for discussion and facilitates the contribution of the participants in the group.

Focus groups offer a number of advantages. First, they facilitate spontaneous discussion among a targeted group on a predetermined topic. A feature of a successful focus group is uninhibited discussion characterised by peer stimulation of ideas and comments. Second, the researcher gains insights with regard to the target population's knowledge, feelings and attitudes towards the topic under discussion. Third, the researcher can obtain the comments and reactions of a number of individuals over a short period of time. Finally, the researcher can quickly identify key issues relevant to the topic under investigation (Bertrand et al., 1992:198). Although the success of a focus group may be undermined by the bias and/or dominance of a particular group member, by a tendency in favour of group consensus rather than individual opinion, and by an inhibition among members over public expression of their views, these pitfalls can be avoided or overcome with appropriate facilitation techniques (Thomas et al., 1992:8).

The advantages offered by the focus group technique were ideally suited to the design of the study. As the initial stage of respondent data collection, the purpose of the focus groups was to act as a catalyst for the project in two ways. The first catalytic function was to stimulate interest in the project. In this respect they were most successful. All the participants enjoyed the experience, many continued to chat outside the meeting venue for some time after the interview, and other Feilding women expressed an interest in being involved. For example, my field notes record that at the conclusion of the first focus group meeting held at the Feilding Community Learning Centre, I was greeted as 'the menopause lady' in the kitchen by a woman who expressed a desire to take part. Two women in the administration office of the Learning Centre also expressed interest in the study, talked about their own experiences and offered to hand out information sheets to women visiting the Centre. The second catalytic function of the focus groups was to act as an exploratory and collaborative tool for the study. The intention was to allow women themselves to identify those issues and concerns they

felt were most important and wanted to have investigated. In this way, the focus groups served very effectively as a tool for the identification and development of themes for the in-depth interviews.

As indicated earlier, participants for the focus groups were recruited through social clubs and word-of-mouth among women in the Feilding area. An initial series of six focus groups were held between mid-September and early November 1995. Five of the focus groups were held in the Feilding Community Learning Centre, while the sixth was held in the library of the Waituna West school, a country school situated approximately fifteen kilometres north-west of Feilding. The date and time of each meeting (held in the afternoon) was organised to suit the respondents. The average duration for the meetings was two hours and the number of women participating ranged from three to eight, with five being the average group size.

In order to create a relaxed atmosphere, the women were offered a cup of tea or coffee and a biscuit on arrival. Once everyone had arrived, introductions were made and the meeting procedure explained. The women were then given the opportunity to withdraw if they did not wish their comments to be recorded on tape, a choice no-one exercised.<sup>31</sup> A consent form was signed and the group undertook to maintain the confidentiality of personal comments made during the course of the meeting.<sup>32</sup> On activation of the tape-recorder, the participants were asked to state their name and age or age group in order of seating so that names could be linked with voices for ease of transcribing.

At each meeting it was only necessary for me to pose the question, 'What do you know about menopause?' to initiate the discussion. From that point onward, little if any facilitation was required until the discussion drew to a natural close after about two hours. There were no problems with the discussion being dominated by a particular person. Although some were shyer than others, the quieter members were given an opportunity to express their views on an issue generally through being asked

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<sup>31</sup> Because I was facilitating the meetings myself, it was essential that the focus groups were tape-recorded.

<sup>32</sup> See Appendix 1.

their opinion by others in the group. Overall, the women had a lot to say, shared some extremely personal information and all were very sympathetic and supportive of each other's experiences. The discussion was lively and frequently punctuated by laughter. The same themes emerged from each focus group, confirming the reliability of the technique for the identification of themes for the in-depth interviews. At the conclusion of each meeting the women were asked if they were interested in participating in the in-depth interviews and very few declined. Following the meeting, each woman was sent a letter thanking her for her involvement in the study.

Two further focus groups were held at later dates. The first, involving five doctors from a Palmerston North group practice, took place in May 1996. In this case, the focus group format was chosen to accommodate the time constraints faced by these busy professionals. The interview was scheduled for the two hour lunch-break allocated by the Practice each week for staff meetings and development. As indicated earlier, two female and three male practitioners participated in the meeting which followed the same procedure as the earlier focus groups. However, the discussion in this case was guided by the themes identified by the women's focus groups, themes that were also used during individual interviews with the other three general practitioners.

The final focus group meeting took place about fifteen months after the original series of meetings and involved seven of the original participants who were selected on the basis of their availability. The decision to run an additional focus group arose from the content analysis of the menopause educational material. Two videos were shown at the meeting with the intention of establishing: i) how informative the women found the material, and ii) the extent to which the medical model of menopause influenced the women's views on the nature and quality of the material presented. The meeting commenced with the usual formalities after which the participants were shown the two videos. Following each viewing a simple questionnaire (in which participants ranked the emphasis placed by the video on certain aspects of menopause) was completed and a discussion of responses to a series of open-ended, pre-formulated questions was tape-recorded. As on the earlier occasions, the women were co-operative, responsive and forthcoming with their comments. Indeed, at one stage during the meeting a

polarisation of opinion over the risks and benefits of HRT appeared to upset three of the women currently on the treatment. Their reactions were quickly picked up by the other group members and amicably resolved. Some of the women also volunteered, along with others unable to attend the meeting, to take home one of two audio-taped programmes in order to complete a postal questionnaire with identical rankings and questions. All the mail questionnaires were completed and returned within the requested time.

Overall, the focus group meetings proved to be a very successful method of eliciting information and stimulating interest in the study. All required minimal facilitation and there were no problems of dominant personalities, strong disagreement or reluctant contributors. Indeed, the only difficulty encountered was occasional poor tape quality arising from noise interference outside the room and 'pick up' difficulties at the final meeting when the larger room required to accommodate the television and video monitor over taxed the capability of the directional microphone.

### *In-depth Interviews*

McCracken (1988:9) argues that the 'long interview is one of the most powerful methods in the qualitative armory'. His point is that the in-depth interview provides revealing descriptive and analytic material which allows the researcher to (McCracken, 1988:9):

...glimpse the categories and logic by which [the respondents] see the world...see the content and pattern of daily experience...and gives [the researcher] the opportunity to step into the mind of another person.

The success of the in-depth interview depends on a number of factors. Of particular importance is the interviewer's ability to 'draw out' the respondent, without actively influencing the narrative, while at the same time maintaining the direction and clarity of the interview. Additionally, the establishment of rapport and the avoidance of active listening (that is, reading and commenting on hidden messages encapsulated in the respondent's speech or body language) are critical (McCracken, 1988:21).

Thirty-two in-depth interviews involving twenty-seven women and five health professionals were carried out between mid-November 1995 and the beginning of May 1996. Each face-to-face interview was arranged and held at a time and place to suit the

respondent, usually the respondent's home or workplace, always began with the signing of a consent form and (with the exception of the health professionals) included the initial completion of a brief demographic survey.<sup>33</sup> The interviews were structured around the themes identified by the focus groups. In the case of the women the themes were: their knowledge and expectations of menopause; menstrual/reproductive history; attitudes of self and others towards menopause; mother's experience; and sources of knowledge and support. In contrast, the interviews with health professionals explored: the respondent's view of menopause; the typical profile of women seeking consultation or information; recommended treatment strategies; and information and support available to women. In all cases the themes were used as a guideline only and the respondents were given ample opportunity to discuss those issues of most concern to themselves. The average duration of each interview was two hours.

Very few problems were encountered during the interviewing process. Only once did an interview have to be re-scheduled and in no case did a respondent withdraw from the study. Occasionally the personal nature of the topic and trauma of reflecting on painful experiences required sensitive and supportive interaction with a respondent. For example, one respondent was near tears for part of the time and care was needed not to unduly distress her. Mindful of the ethical responsibility of protecting research participants from harm, I reminded the respondent that she was not obliged to continue with the interview. She choose not to exercise this option, indicating that while talking about her experience was upsetting it was also helpful. In common with this respondent a number of the women remarked on the benefit of being able to articulate their menopause experience. The only other difficulty encountered involved the recording equipment during the early stages of data collection. A very small activator switch on the recorder microphone was inadvertently knocked or left off on three occasions. The resultant blank tape meant that notes made from memory were substituted for a transcript. The problem was ultimately resolved through a change of equipment.

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<sup>33</sup> See Appendix 1 and Appendix 3.

As in the case of the focus groups, the interviewing process was characterised by the enthusiasm, co-operation and support of the respondents. All were very hospitable, most had morning or afternoon tea awaiting my arrival and even the occasional meal was prepared. Several times a respondent telephoned after the interview, anxious to clarify or add to the information given. Overall, their positive response towards their involvement in the study was both humbling and a poignant reminder of a researcher's responsibility to participants - in this case to provide an opportunity for their voices to be heard.

### *Narratives*

Twenty-nine *NZWD* respondents submitted narratives in written responses to a guide sheet.<sup>34</sup> The purpose of the guide sheet, which listed a suggested range of opened-ended questions based on the focus group themes, was to stimulate rather than direct the women's comments. In fact, most of the responses adhered closely to the questions and some were even written directly onto the guide sheet. Generally the women's replies were two to three pages in length although a few were longer. As with the Feilding-Manawatu women, the *NZWD* respondents were supportive and enthusiastic about the project and a number indicated they appreciated the opportunity to write about their experiences.

### **Data Analysis**

In the following pages the data analysis procedures employed for each of the data collection methods is outlined. The study as a whole employed inductive analysis, that is the formulation of generalisations based on the observation of phenomena. In order to effectively process the large amount of data in a manner which facilitated the identification of general patterns and themes without losing the uniqueness of individual cases, the method of cross case analysis was employed with each of the data sets. This technique is usually used in studies with a common focus and involves 'grouping together answers from different people to common questions or analysing different perspectives on central issues' (Patton, 1990:376). As a methodology, a cross case analysis offers two advantages: it provides a method of synthesising a large

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<sup>34</sup> See Appendix 4.

amount of data and a wide range of data sources; and it facilitates the development of theory through induction and interpretation (Patton, 1990:425). Finally, it should be noted that throughout the process of synthesising and analysing data a diary was kept to record thoughts, ideas, references and other material of possible relevance for inclusion in the study.

### *The Literature Review*

The method of classification and analysis of the literature on menopause has been detailed and discussed earlier in this chapter and in Chapter 1.

### *Content Analysis*

The conceptual framework for the content analysis was the construction of menopause as a life-stage or deficiency disease. The units of analysis were the three workshops, audio-tapes and video tapes and printed articles or pamphlets. In the case of the three workshops, the absence of direct transcripts meant that the analysis was dependent on the detail and quality of field notes. This required modification of the usual technique of quantification of key words in favour of a system of identifying and classifying manifest characteristics on the basis of 'who says what, to whom, why, how, and with what effect' (Babbie, 1992:314). Once identified, the manifest content of each workshop was examined for the type of emphasis placed on menopause (e.g. as a medical or social event), language used to describe symptoms and changes, type of management strategies advocated, and so on. In this way, the underlying or latent content of each artefact became apparent.<sup>35</sup>

In the case of the audio-tapes, video tapes and printed artefacts a conventional content analysis was carried out. However, the first step towards determining the manifest content of the audio-visual material was to transcribe the script of each video and audio-tape. During this process the usage of certain key words quickly became apparent with a list being compiled as the task was being completed. Examination of the completed list of key words identified three categories of physiology, symptoms and lifestyle which could be further classified as conforming to either the deficiency

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<sup>35</sup> See Figure 4.1.

disease model or the life-stage model of menopause.<sup>36</sup> In this way the latent content of each artefact could be quantified through key word usage frequency.<sup>37</sup> The same analytical procedure was applied to each of the printed items.

### *Focus Groups*

On completion of the first six focus groups, the interview tapes were transcribed and the material classified into themes. Separate transcripts of each respondent and individual themes were then collated, collapsed into generic categories with sub-headings and cross-referenced through entering the line and page numbers on a master sheet. The themes identified from the focus groups, via the technique of cross case analysis, were: alternative therapy; attitudes towards menopause; definition of menopause; doctor information; doctor relationships; expectations; HRT; hysterectomy; knowledge and knowledge sources; male attitudes; menopause support groups; mid-life/empty nest; periods/menstruation; reaction to study; relationships with friends/others; relationship with mother; relationship with spouse; sex life; symptoms; tranquillisers; too young for menopause. These themes were then condensed into the following five categories which guided the in-depth interviewing process: definition of menopause; experience/expectations; attitudes; relationships; and knowledge.

The general practitioner focus group interview was transcribed and the comments of each practitioner collated and processed as described above. In the case of the focus group concerned with menopause educational material, in addition to the taped interview processed as described above, respondents completed a brief questionnaire which required them to rank the emphasis placed on key concepts presented in each programme.<sup>38</sup> An identical questionnaire was also completed (in relation to material presented in two audio-tape programmes) by another thirteen women unable to attend the focus group. The questionnaire data was processed through identification of response frequencies and mean scores on the ranking scales.

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<sup>36</sup> See Figures 4.2 and 4.3.

<sup>37</sup> See Figures 4.4 and 4.5.

<sup>38</sup> See Appendix 6.

### *In-depth Interviews and Respondent Narratives*

As with the focus group material, all interviews were transcribed, collated and cross-referenced under both the name of the respondent and the originally identified themes and sub-themes.<sup>39</sup> In this way complete narratives as well as individual quotes were readily accessible for analysis. The process of analysis itself involved the further refinement of classificatory categories in accord with the aims and objectives of a particular chapter. A file for each chapter was compiled and contained a relevant master sheet, transcripts and summary tables which allowed quick comparison (using the technique of cross case analysis) of the women's attitudes, expectations and experiences.

## **CONCLUSION**

This chapter has identified and described the theoretical orientation and methodology of this thesis. It commenced with a critical evaluation of each of the three theoretical orientations identified in the literature review in order to identify a theoretical approach which would accommodate an examination of the interaction between women's experience and broader socio-historical factors. The discussion highlighted the principal strengths and weaknesses of each orientation and the blurred boundaries along the interface of theoretical spaces. The realist nature of the biomedical/positivist orientation was rejected in favour of the relativist perspective of the constructivist/critical orientation and the predominantly relativist perspective of the humanistic/interpretive orientation. In the case of the two latter orientations, their respective disregard for social context and agency diminished towards their mutual boundary. Accordingly, a constructivist/interpretive orientation, representing the overlap between the two perspectives was identified as the theoretical orientation to be employed for the thesis.

Aside from the brief definition and/or discussion of six concepts important to the analysis and interpretation of data collected, the focus of the remainder of the chapter was on the study methodology. The town of Feilding and the surrounding Manawatu

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<sup>39</sup> The *NZWD* responses were also typed into the computer in order to allow processing in the same manner as the other material.

district was the central site for the study. A total of seventy-four respondents were recruited through non-probability sampling techniques. The main group of respondents were from the Feilding-Manawatu district and participated in a series of focus group meetings and in-depth interviews. The two other groups were women contacted through a letter in a national women's magazine, and local doctors and NZFPA menopause educators. The study employed an inductive approach in conjunction with cross case analysis for each of the six data sets generated from the literature review, content analysis, focus groups, in-depth interviews and respondent narratives.

## Chapter 3

### Deficiency Disease or Normal Life-Stage?

Throughout the history of medicine, clinical observation and experience has been the basic tool of physicians in acquiring and accumulating knowledge. However, the information from such observation can only be considered useful if its limitations are fully recognised... With regard to the menopause...there is a consistent omission as to the objectivity and generalizability of [such] observations...menopausal symptomology, its origin and treatment, is repeatedly described with no empirical basis other than 'experience'.

(McKinlay and McKinlay, 1973:53)

Coney (1993:72-73) observes that despite the lapse of twenty years since the McKinlays' publication, controversy continues over almost every aspect of menopause. In particular, there is a lack of universal agreement on what menopause actually is and how it should be defined and managed. As already indicated, medical knowledge is underpinned by certain fundamental assumptions, particularly the privilege accorded positivist knowledge and the separation of mind from matter which, in turn, promotes the mechanistic view of physiological functioning. As a result a tradition has evolved within which the objective and value-free nature of medical knowledge has become the dominant view; that is, one accepted by the profession and public alike. As demonstrated by Lock's (1982) study of Canadian clinicians, however, medical professionals do not operate independently of the social context.<sup>1</sup> Indeed, in the case of menopause, there is the well known example of the socially informed clinical views of oestrogen pioneer Robert Wilson (1966:54), who promoted his treatment as one that allowed women to 'remain feminine forever'. Although dismissed by many of his colleagues as a crank (Coney, 1993:60), the point to be made is that whether medical practitioners admit it or not, their clinical views, practice and decisions inevitably reflect dominant social values and beliefs. Indeed, the latter appear to be an influential factor in the controversy identified by the McKinlays (1973) and Coney (1993).

Against such a background, this chapter aims to identify the definitions of menopause held

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<sup>1</sup> See Chapter 1 for details of Lock's (1982) study.

among a group of local general practitioners and Australasian specialist consultants and to explore those factors which inform their views. The implications of these views for clinical practice is examined and their potential influence on women's perceptions and experience of menopause is indicated.

### **THE NEW ZEALAND MEDICAL PROFESSION**

Prior to 1860 there was no national system of medical licensing, professional organisation or characteristic, other than the title of 'doctor', to distinguish between the training or expertise of individual practitioners in New Zealand (Belgrave, 1991:7). The establishment of a medical school at the University of Otago in 1875, signalled an end to the colony's total reliance on overseas trained practitioners, with the first student qualifying as a doctor in 1887.<sup>2</sup> During the early years, the fledging medical school struggled against a lack of funding and resources with the majority of medical students preferring to train overseas. Following the outbreak of World War I, when overseas travel was restricted, there was a dramatic increase in the school's student numbers. As a result the school's academic and professional profile were raised and its public recognition as a national institution was achieved (Maclean, 1966:531). A second medical school was established in the early 1970s, at The University of Auckland. Although it is not uncommon for New Zealand medical students pursuing specialist postgraduate qualifications to obtain some overseas training, the current situation is that the majority of doctors graduate locally.

The first female medical student graduated from Otago in 1891. However, despite the increased number of women entering medical training over the last three decades, the New Zealand medical profession retains a traditional patriarchal structure. White (1994:243), for example, points out that:

... women graduates do not go on to postgraduate work, or to positions in teaching hospitals. They typically end up in part-time GP work, with similar caseloads and lower fees than their male colleagues.

To put this observation into perspective, it may be noted that for all but one year during the period 1973-1985, female medical students at Auckland Medical School, despite being a

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<sup>2</sup> The University of Otago, New Zealand's oldest university, is located in Dunedin.

minority group, achieved higher grades than the men (White, 1994:243).

Within New Zealand, general practitioners are front-line health professionals consulted on a wide range of problems. The nature of their work not only brings them into daily contact with patients and their families but facilitates the establishment of ongoing professional relationships which may extend over many years. As a result there is a potential for the doctor/patient relationship to move beyond the purely clinical level as the practitioner becomes cognisant with the patient's health history and personal circumstances. As one of the doctors in this study explained, many patients become like 'old friends' and in such circumstances it is not uncommon for a situation of mutual understanding and trust to develop.

As their name suggests, specialist consultants undergo intensive postgraduate training in a particular area or field of medical practice. Within the medical profession they are regarded as experts in their field and accorded status and respect by fellow professionals and patients alike. Unlike the general practitioners, the nature of their practice does not facilitate the establishment of long-term relationships with a particular patient nor are they likely to have more than superficial contact with members of the patient's family. In New Zealand, patient access to a specialist consultant is normally only possible through a general practitioner's referral. Once a problem is diagnosed and treated or stabilised the patient reverts to the care of the general practitioner. If the patient has an ongoing condition, maintenance treatment is carried out by the general practitioner in direct consultation with the specialist. For the majority of specialist consultants an important aspect of their professional activity is hospital consultation which may, as in the case of gynaecologists, include surgery. The hierarchical structure of the hospital situation further enhances their professional status, authority and expertise within the medical profession while reinforcing their formal, distanced relationship with patients.

### **SCIENCE AND BIOMEDICAL KNOWLEDGE**

Medical science or biomedicine has developed within a particular European socio-historical context and so represents a culturally distinct view of reality (Lock, 1988:45). Fundamental

to the biomedical view of the body and its functioning, health and illness are the assumptions of science.

The birth of modern science during the period referred to as the Enlightenment coincided with a time of social and political change stimulated by technological discovery and development. Seventeenth century production of mechanistic devices such as clocks and the telescope contributed to a new and radical interpretation of the nature of the universe. The traditional authority of the church was challenged, overturned and a biblical explanation of reality was rejected in favour of a materialistic and empiricist, or 'scientific', way of knowing. Redefinition of nature as a tangible, ordered entity, functioning according to specific laws independently of social, cultural or supernatural forces, was accompanied by a fundamental shift in attitude toward natural phenomena. The former creed of living in harmony with and respecting nature was replaced by a desire to harness and control natural phenomena (Griffiths, 1989:113). The body, now recognised as nature's human representative, was perceived as scientifically knowable and controllable. Illness and disease, previously regarded as products of sin, were redefined as empirically knowable physiological malfunctions (Gordon, 1988:24).

Fundamental to the scientific paradigm is the influence of Cartesian-Newtonian thought. As Capra (1982:118) points out:

... the mechanistic view of life, once firmly established in biology, has dominated the attitudes of physicians toward health and illness. The influence of the Cartesian paradigm on medical thought resulted in the... biomedical model, which constitutes the conceptual foundation of modern scientific medicine.

The result has been a dualistic, reductionist and mechanistic view of the body as a functioning machine operating independently of the mind. Consequently, the focus of biomedicine is on physiological processes while the realm of consciousness is dismissed as largely unknowable and therefore irrelevant. Accompanying the focus on physiological processes is an assumption of the universality of bodily functioning and experience and an emphasis on cause/effect relationships as prime characteristics of health and illness.<sup>3</sup> As a branch of positivist science, medical knowledge assumes possession of the truth through the

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<sup>3</sup> See Manning and Fabrega (1973).

process of descriptive, objective, value-free application of deductive reasoning which involves methodological replicability, reliability and validity.

As will be discussed in the following pages, the biomedical view of physiological functioning, health and illness has a number of implications for menopause. The separation of mind from body restricts the focus to physiological changes at the expense of consideration of the impact of personal, experiential and social factors. The emphasis on cause/effect mechanisms encourages a reductionist view of menopause as a process of hormonal decline. The outcome is the redefinition of a normal bodily process as pathological which in turn invites and encourages the medicalisation of menopause.

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### **MENOPAUSE AS A HORMONE DEFICIENCY DISEASE**

Friedson (1970, cited in McCrea, 1983:112) argues that 'medicine...is orientated to seeking out and finding illness [that is] it seeks to create social meanings of illness where that meaning or interpretation was lacking before'. The identification and development of sex hormones earlier this century and the availability of synthetic oestrogen in the early 1960s facilitated medical redefinition of menopause as a deficiency disease (see Oudshoorn, 1994). Through the seventeenth and eighteenth centuries and the first half of the nineteenth century, difficulties experienced by women at menopause were generally put down to individual failure, initially as the result of sin and later personal weakness in the form of neurosis. Indeed, during the period following World War II up until the early 1960s, the treatment of symptoms with psychotropic drugs was not uncommon. The absence of tangible evidence of physiological malfunction at this time meant that menopause was not considered a physical disorder and so treatment was largely regarded by doctors as outside the scope of medical science. As Coney (1993:56) points out:

Until the 1960s doctors were not much interested in the menopause. It was simply something their female patients went through and if women came to them with their complaints, they were likely to be told it was just to be put up with...there were no operations, no complex tests, no wonder drugs...

However, the identification of sex hormones and the discovery of synthetic oestrogen in the 1960s, revolutionised the medical view of menopause. Redefined as a process of diminished ovarian activity and an associated decline in oestrogen levels, menopause no longer fell

outside the scope of medical science. Indeed, as a deficiency disease, menopause could now be treated in a manner akin to diabetes or thyroid dysfunction.

The deficiency disease view meant that earlier perceptions of menopause as a normal life-stage to be stoically endured were challenged. The impact of lower oestrogen levels was linked with an increased risk of coronary heart disease and, in later life, osteoporosis. Viewed in this way menopause could be redefined as a health hazard, the experience of symptoms was legitimised and the notion of the need for medical monitoring and management was seeded. Furthermore, recognition of the commercial potential associated with the discovery of oestrogen generated controversy and debate as to the accuracy of research on the advantages and disadvantages of hormone replacement therapy (HRT). Within the medical profession and scientific literature, perceptions of menopause - its symptoms, management and treatment - vary and the debate continues as to whether it should be regarded as a normal stage in women's lives or as a hormone deficiency disease.

## **GENERAL PRACTITIONER PERSPECTIVES**

Given the controversy surrounding medical definition and treatment of menopause, the professional views and clinical practices of eight local general practitioners are examined and discussed. As requested, they will be identified throughout the discussion as: Dr.M, Murray, Lindsay, BC, Wayne, Warren, Zoe and Inga.

The most common initial presentations for menopause were identified as follows:

...the majority of women come in their mid to late forties just asking what is going to happen and whether they need to go on treatment.

(BC)

...sometimes [women want to know] whether what they have got at the moment might be menopause. That's a very common presentation.

(Dr.M)

...there is a great range of presentations from just information, to treatment for the symptoms, to treatment for the complications.

(Warren)

...tiredness. The classic one they come in saying is...hot flushes and night sweats... but when you actually talk to a lot of women the commonest thing that annoys them is that they are tired.

(Inga)

...they are almost always in that sort of mood disturbance sort of thing.

(Wayne)

## Definition of Menopause and Related Symptoms

### *Menopause as a Life-stage*

Among the eight general practitioners, Dr M emerged as the strongest advocate of a life-stage view of menopause. His stance reflected his personal philosophy and experience:

I am a great one for these [developmental] stages in a person's life...Most stages in my life and other people's lives are marked by these transitions...by grief and things opening up, so that they are actually both these things. So I think...[menopause]...is moving on. [What] marks it quite obviously...[is that] periods stop.

Lindsay, on the other hand, referred to the experience of his wife and close female friends as being important in the formation of his view:

...with a wife and friends of [an] age that have moved through this...by and large I see it as a very positive thing. It's a time of life when women suddenly are unburdened. Not that they are necessarily old. They have actually got much of their life left and are generally fit. They can do all sorts of things...

BC admitted that her view of menopause as a positive life-stage, was reached through talking with female patients. She felt that while it was true that not all women experienced menopause in the same way, for many it represented freedom from contraception and childrearing and the opportunity to 'do their own thing a bit more'. In contrast, Murray's view was influenced by his mother's experiences:

I remembered my mother saying to me that being a woman was pretty tough really. Puberty was hard enough and after that you still had childrearing to go through and when you had finished that then you still had the menopause to look forward to. It's the final straw really.

As a result, Murray viewed menopause as:

A very big physical and emotional event [involving] a lot of physical changes...that are not very pleasant. I think for many women it signals the end of youth really, the end of childbearing, the beginning of old age.

Aware that his view was confirmed by his clinical experience, Murray also noted that 'women who have [a] positive experience don't come to me, they don't need to, only those who are finding it a negative experience [come to me]'.

### *Biological Change and Social Factors*

A lot of women come in somewhere in their mid thirties, late thirties, all worried about [menopause and they ask] are they going through the menopause? ...you have to look at the social situation, the context, in order to try and decide on the meaning of the [symptoms] for the patient.

(Wayne)

In contrast with their colleagues, both Warren and Wayne emphasised the biological nature of menopause and focused on the social factors associated with reported symptoms in the

clinical situation. Additionally, both identified discrepancies between their medical knowledge and clinical experience. Wayne put it this way:

...we were all told at medical school that menopause can happen at any age...I think menopause happens around the age of fifty just like the old text books said it happens [but] I suppose like any normal distribution curve there will be extremes...if you actually get down and measure hormone levels...often women who may have some menopausal-type symptoms in their...late thirties, early forties have got absolutely normal blood hormone levels.

Warren's comments suggested a similar experience. 'The most common symptoms I find...[are] mood swings. That surprised me because we were always told [at medical school] that the hot flushes were important.'

The arbitrary nature of the biomedical definition of menopause has been noted by Kaufert et al. (1987:217) who observed that 'the processes of hormonal change which mark the end of a woman's reproductive years are relatively uncharted'. The authors point out that the customary medical definition of menopause was developed in response to the need for a standardised criteria for research purposes. The resultant definition, formulated by epidemiologists, was based on the *assumption* of a relationship between menstrual patterns and hormonal activity rather than actual hormonal measurement. Menopause is consequently defined as a woman's last menses; a woman is post-menopausal if she has not menstruated for over one year and is pre- or peri-menopausal if menstruating irregularly (Kaufert et al., 1987:217). The difficulty is that these categories are not necessarily commensurate with women's perception of the stage they have reached in the process of menopause. Moreover, in the absence of an empirically based definition, it cannot be established whether the customary definitions present an accurate representation of what is happening to a woman's body (Kaufert et al., 1987:225). As identified at the beginning of this chapter, similar sentiments are expressed by Coney (1993:72) who notes that 'question marks [exist] over almost every aspect of menopause [with]...no universal agreement over what menopause actually is' being reached. Coney (1993:72) illustrates her argument by pointing out that between one and forty symptoms have been attributed to menopause by various researchers.

The arbitrary nature of the definition of menopause, and uncertainty surrounding related symptoms, meant that the eight general practitioners interviewed lacked clear guidelines on the nature and treatment of this event. In response to the latter, Wayne had adopted a

strategy of undertaking ‘a very careful consultation’. In addition to identifying physical changes, his strategy involved consideration of the meaning of symptoms within the context of a woman’s social circumstances. Wayne remarked that it was easy to distinguish ‘oestrogen deficiency symptoms...flushes, vaginal dryness...those sorts of things’, as clinical experience had taught him that such conditions usually responded well to hormone-type treatments. However, in the area of less tangible symptoms, Wayne acknowledged:

I personally find that one of the hardest things to sort out is your depressed woman [sic] in her late forties, early fifties. [It] is frightfully hard to try and sort out whether you are dealing with depression or whether you are dealing with menopause...it’s really complicated.

Although aware that symptoms such as depression can occur at other stages in life and fall outside those empirically linked with menopause, Wayne’s professional experience appears to have taught him otherwise.

### **Knowledge of the Risks and Benefits of HRT**

The concern over the lack of clear guidelines on the symptoms and treatment of menopause expressed by the general practitioners was particularly evident in relation to the use of HRT. Dr. M commented on the positive bias displayed by the specialists who promoted the ability of HRT to extend both a woman’s life span and quality of life. Warren, on the other hand, expressed disquiet at the lack of information on possible adverse effects:

...some of the treatments do have ‘side-effects’, some have risks too. No one really knows [what the risks are] so you have got to weigh up the pluses with the minuses and at the moment I don’t know the answer.

Wayne raised the issue of prescribing HRT as a preventative measure:

I just don’t know what the right thing to do is. I think if you have got someone with established osteoporosis and they are young enough you might be keen to use HRT, but most of them aren’t. It might correct it, there is some evidence coming out....I mean it is bloody confusing!

BC pointed out that in her experience, because of the fairly nebulous medical evidence concerning its benefits, very few women were prepared to take HRT for more than five years. Lindsay’s comments also reflected on the current state of medical knowledge concerning HRT:

I have just been to this [course] on evidence-based medicine....They pointed out there is very poor evidence to do with guidelines on HRT. There is a lot of information but it is not very critically evaluated.

He noted, for example, the lack of clarity associated with the guidelines put out by the American Medical Association, whose recommendations he regarded as ‘full of value judgements [but] they don’t declare where their values come from’.

The issue of value bias underlying medical knowledge on menopause has been addressed by a number of social science and feminist researchers.<sup>4</sup> Oudshoorn (1994:16), in a critical examination of the development of sex hormones, argues that the notion of sex hormones as chemical messengers active in promoting gender characteristics was originally believed by scientists to hold ‘the key to understanding what made a man a man and a woman a woman’. From this perspective, the ovaries, as the producers of oestrogen (the prime female hormone), were confirmed as ‘the essence of femininity itself’. Menopause, as a condition of ‘ovarian failure’ and ‘oestrogen deficiency’, could then be presented as a challenge to a woman’s femininity (Oudshoorn, 1994:19). Indeed, Wilson, the originator of oestrogen therapy for the treatment of menopause, regarded post-menopausal women as ‘castrates’ and promoted the benefits of HRT in maintaining a trim figure and nubile breasts in addition to diminishing wrinkles and ‘saggy’ skin.

Wilson’s (1966) mission of ensuring women remained ‘feminine forever’ is illustrative of the value judgements which shape medical knowledge and treatment. More to the point, Wilson’s recognition of menopause as a process of ovarian failure and oestrogen deficiency has endured and remains fundamental to the promotion of HRT. The problem is, that medical redefinition of menopause as a deficiency disease disregards the socio-cultural and experiential aspects of this stage in women’s lives. Moreover, it diminishes the significance of menopause as a normal stage in the process of ageing. The outcome is the conversion of a normal process into a health hazard (Kaufert and Gilbert, 1986:9), as will be evident in the views of the specialist consultants presented later in this chapter.

### *A Hazardous Life-stage*

In contrast with their colleagues, Zoe and Inga were open to the notion of menopause as a health hazard. Both these practitioners were consulted by predominantly female patients, saw more women who were experiencing menopause-related problems and had extensive

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<sup>4</sup> See, for example, Coney (1992), Dumble (1992), Coney (1993) and Voda (1993).

clinical experience in the area of women's health. Although they acknowledged menopause as a life-stage event, they nevertheless advocated medical management of menopause through treatment with HRT.

Zoe, who viewed menopause as a positive stage in women's lives, commented:

I find that at least half the women I see say that they are relieved they don't have periods any more [as] often their periods have been an interference with their lives. I normally talk through what can be done to solve their other symptoms and when they realise that they can actually solve that, and not have to have periods either, they think it is really good.

It was clear that Zoe's professional contact with women experiencing problems had influenced her view of menopause. Moreover, it provided her with confidence in her clinical ability to successfully treat unpleasant side-effects and indicated her unwillingness to 'buy in' to the view that women should stoically endure severe symptoms. '[I] see women come into me miserable and come back later and say that they can live their lives properly again.' Inga, on the other hand, acknowledged menopause as 'a stage in life which medical science has the ability to modify' but was aware also of the impact of socio-cultural influences on women's experience:

If you look at certain cultures in the world, the elderly, wise old women don't have nearly the same problems with menopause as Western culture. If you become the wise old crone you suddenly don't have all these responsibilities...you [achieve] status in the society in which you live. You feel good about yourself...people revere you and you don't have problems with depression, loss of concentration and everything like that.

She viewed menopause as a recent phenomenon brought about by an increase in longevity associated with late nineteenth and twentieth century socio-medical developments:

...basically menopause is a stage where oestrogen becomes lacking and if we go back in years, women didn't live beyond forty or fifty. Now the vast majority of women will live a quarter or third of their life span post-menopause. So there is a debate - is it natural for a woman?

In common with some of the other practitioners, Inga identified a tension existing between the patient's definition and the medical definition of menopause:

Most people, when they refer to menopause, talk about all the other issues that go on around that time...things like hot flushes, the night sweats, lost concentration and depression and tearfulness and irritability. I mean these are what women call the menopause, so I accept that [definition].

Aware that acceptance of her patients' view placed her at odds with the biomedical definition of menopause as the end of menstruation, Inga noted 'the trouble is that women can say they are going through menopause long before their periods stop'. She resolved the

difficulty by professionally adopting a modified view which allowed her to acknowledge symptoms such as tiredness as being menopause related. As her comments signalled, in many respects Inga presented the most complex, contradictory and socially focused view of all the practitioners.

### **Prescribing Strategies**

The comments of the general practitioners suggest they did not wholeheartedly accept the view of menopause as a health hazard. Moreover, the ambiguities surrounding the medical definition, knowledge and treatment of menopause led them to overlay professional knowledge with social explanation. Dr. M described his approach in this way:

[I inform the woman that] some [doctors] see [menopause] as a deficiency state like thyroid and others as a normal ageing thing which [a woman] has got to adjust to. I don't actually say which one I believe...I don't know which of the two either, so I actually signal there is a philosophical problem around this. [I tell the woman] you are going to have to make up your mind about this...you can either take pills or not depending on your inclination.

Warren's strategy was to explain bodily changes at menopause and to follow this with an outline of treatment options so that the woman could decide on how to best manage unpleasant symptoms. If the woman opted to go on HRT, he implemented a three month trial period which was followed by further discussion and reassessment. Warren did, however, point to a 'grey area' surrounding the optimum duration of treatment with HRT:

...how long do you keep them on it for...I quote C [a local specialist]. His policy is that [HRT] should stay there forever as a replacement drug. He sees [menopause as the result of] an organ that has stopped producing a natural hormone [which] should be replaced.

Despite such expert opinion on the long-term use of HRT in post-menopausal women, Warren remained concerned about its unknown side-effects:

...at the moment, with the knowledge that I have, I am happy for them to stay on [HRT] some length of time, like four years. I haven't got the knowledge to say they should stay on it for any longer than that. I don't think anyone has. It's a grey area, no one knows.

Faced with a situation of uncertainties, he adopted the following consultation strategy:

I leave it in the lap of the women. I say 'After three months come back, see how you feel' and then every year they have to be reviewed anyway. You give them the options all the way along.

Wayne held a similar view:

You should be able to justify every intervention, every prescription...if you have your hesitations about this osteoporosis stuff perhaps you get back to what is essentially symptomatic treatment...then it is your patient who has to decide whether the symptoms warrant the treatment.

The need for careful monitoring of all women on hormone replacement therapy was seen as essential by all of the practitioners. This involved regular pelvic examinations and smear tests in addition to mammography, blood pressure and weight checks. Moreover, each practitioner viewed such a regime as a 'negotiated' condition of treatment, even though prescription renewal was commonly dependent on a monitoring consultation. Although such a strategy appeared philosophically at odds with the practitioners' life-stage view of menopause, Wayne explained the situation this way:

...things can be over medicalised but to a degree that's the rules. That's how the game is played and if we want to enter into it, that's what you have to do.

As with prescribing guidelines, some of the practitioners looked to local specialists for direction on monitoring strategies. Murray, for example, indicated that he tried:

...to follow C's [a local specialist's] model [which] if I remember rightly is six monthly weight and blood pressure, routine or two yearly mammograms and two to three yearly pelvic examinations which should be done at the time of their routine smear.

Aware of the rigours of such a regime, Murray pointed out that all women over fifty were offered routine mammograms and many already underwent regular blood pressure checks and routine smear tests. He did, however, express concern over increasing publicity linking menopause with HRT, believing such an emphasis obscured other aspects of this event. In an attempt to compensate for such a bias his approach was to 'reassure [women] that if they don't take HRT it doesn't mean that they are going to get osteoporosis'.

Murray's strategy of adherence to specialist guidelines when monitoring patients on HRT can be seen as a reflection of two factors. The first concerned the small number of women who sought consultation for menopause related difficulties. 'I probably [have] only about half a dozen women on HRT...they are very few...I have got a very young practice!'. And the second factor was the fact that as a general practitioner he simply did not have the time to keep abreast with the latest clinical developments in every area, particularly one where he saw very few patients. As a result, he felt relatively inexperienced in the clinical management of menopause and so adhered to protocols advocated by a local specialist who he regarded as an expert in the field.

A similar situation was signalled by some of the other practitioners who adopted a strategy of only prescribing from a limited range of hormone drugs which they knew from

experience to be effective. Warren, for example, prescribed ‘just one or two preparations’ while BC preferred to use those drugs which she knew would allow her to ‘alter the progesterone easily [so as to be able] to do some fine tuning. For those [women] who have had side-effects before’. Wayne summed up the situation with the comment: ‘Our problem is that for all the trial[ing] and all the official medicalised stuff, your practice is often anecdotal and your individual patient is an anecdote themselves.’

In contrast, Zoe’s practice strategies reflected her conviction with regard to the benefits of HRT for all women at menopause. ‘I suppose I am a strong believer in HRT and say [to patients] ‘Even if you don’t have symptoms then replacement can help you because of x, y and z’’. Despite this view, she rejected the notion of menopause as a deficiency disease and resolved any contradictions by viewing it as a process which frequently requires medical assistance to alleviate symptoms. ‘I am seeing women who are right in the middle of the worst [symptoms]. Maybe I see the worst cases...somebody said we don’t see women who sail through it!’ Aware of her bias, Zoe took care to make her view apparent to women during the course of the consultation. ‘I always stress [to the patient] that I am in favour of HRT [and tell them] you must remember this when I talk to you.’ Underlying this tactic was her belief that successful consultation and treatment strategies depended on accommodating patient values and beliefs with medical knowledge:

... a lot of my patients have a battle with themselves deciding [whether to go on HRT]. They don’t like taking tablets [which] like drugs are not part of them. They battle that versus their symptoms. I say, ‘I am going to have to put that [decision] back onto you, because you are the only one who can make that decision’. But it’s a tough one and they recognise that it’s a tough one.

Inga, in common with the other general practitioners, emphasised the importance of informed patient choice of treatment strategies. Like Zoe, Inga (who was also frequently consulted by women experiencing severe symptoms) was convinced of the benefits of HRT:

I think that women have the right to be informed about [HRT]. There are very few situations in which it would be life threatening or dangerous so it comes down to an informed choice. I suggest it to everyone I can...that this is available. Do they know about it and have they thought about it?

Contributing to Inga’s practice strategies was considerable professional experience in the area of women’s health. The latter was especially evident in her belief in the need for women to undergo regular physical check-ups:

Women are terribly good at bringing their children and their partners to the doctor and they are terrible about making time for themselves, apart from maybe turning up for a smear test. So when we get down to the physical side of things we discuss a 'warrant of fitness' and what level of testing we do and ultimately they choose.

The reference to a 'warrant of fitness' is indicative of Inga's unconscious, metaphoric, mechanistic view of the body and its functioning. In New Zealand, a 'warrant of fitness' is commonly understood to refer to the legal requirement for all motor vehicles to undergo a six-monthly mechanical check to ensure their road worthiness.

Although Inga did not appear to share the doubts of other practitioners over risks associated with the use of HRT, she nevertheless stressed her 'medical/legal' responsibility to provide comprehensive monitoring for women on the treatment 'to make sure they are safe on what I am giving them'.<sup>5</sup> Although such a strategy can be viewed as contributing to and perpetuating the medicalisation of menopause, a practitioner (as Inga rightly pointed out) who prescribes HRT is morally and ethically obliged to implement a monitoring regime. In other words, the practitioner has no choice. Unlike Zoe, however, Inga did not appear to associate regular monitoring with the medicalisation of menopause. Instead, she emphasised her professional obligation to ensure early detection of treatment side-effects in the interest of patient safety.

Ambiguities associated with the view of menopause as a health hazard, and uncertainty surrounding the use of HRT, emerged through the consultation and prescribing strategies of most of the practitioners. In contrast with their colleagues, both Zoe and Inga promoted the view of menopause as a treatable, physical process. In the consultation setting, each focused on educating women about the biological nature of menopause and the advantages of both medical management and treatment of symptoms. Despite this strategy, Inga acknowledged the importance of consideration of the impact of non-medical factors on women's symptoms. However, she also qualified her view with the comment 'I don't necessarily know that we could actually work out what component of the psychological things are life related, culture related, belief related, family related or oestrogen related' and so signalled some of the uncertainty shared by her colleagues. In other words, the more biomedically orientated clinical approach adopted by Zoe and Inga may in fact have been a further

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<sup>5</sup> 'Medical/legal' was the term used by Inga.

manifestation of the ambiguities surrounding menopause. The point is that by emphasising the clinical monitoring and treatment of menopause, these two practitioners appear to have felt that they exercised greater control and accountability over their professional activities. It is also equally possible that, as female practitioners, they experienced greater pressure from their patients to provide effective relief for symptoms and encountered an expectation that they would prescribe HRT. Whatever the reasons, Zoe and Inga undoubtedly placed the least emphasis of all the general practitioners interviewed on the social aspects of menopause during consultation.

### **IMPLICATIONS OF GENERAL PRACTITIONER VIEWS AND CLINICAL STRATEGIES**

The preceding discussion has drawn attention to the impact of personal and professional experience and medical knowledge on the views and clinical strategies of general practitioners. It is clear that although all the practitioners viewed menopause as a normal stage of the life cycle, they adopted different strategies in the clinical situation.

Lock's (1982:269-272) study of a group of Canadian clinicians found that under circumstances of confusing or contradictory knowledge, clinical decisions were more likely to be influenced by a range of non-medical factors such as personal attitudes and values, professional training and the nature of the patient population. She noted, for example, that the clinicians who acknowledged menopause as a 'time of loss' adhered to biomedically orientated consultation procedures such as diagnostic testing to determine menopausal status and treatment of symptoms with HRT. In contrast, those who viewed menopause as a 'biopsychosocial' process emphasised the social origin of symptoms, rarely prescribed HRT and advocated alternative therapies such as counselling for the management of symptoms.

A similar situation is evident among the local practitioners. For both Zoe and Inga the view of menopause as an event which could be effectively managed with HRT was informed by their clinical experience. Zoe, who noted that she 'maybe...[saw] the worst cases', had found HRT to be extremely effective in relieving the symptoms of her patients. Inga, who shared a similar professional experience, viewed HRT as both a treatment strategy and a health promotion strategy. In contrast, their colleagues, who saw fewer menopausal

patients, placed more emphasis on a woman's social circumstances and were reluctant to prescribe hormone treatment. Indeed, the absence of clear clinical guidelines, combined with relative inexperience in the management of menopause, led this group of practitioners to develop strategies to minimise the possible adverse effects of treatment decisions. As indicated earlier, these strategies included: prescribing from a limited but familiar range of medications; avoidance of new and/or different pharmaceutical products; and patient referral to and/or adoption of a local specialist's prescribing and monitoring protocols.

What is interesting about this last strategy in particular, is that it involved procedures philosophically at odds with the practitioners' life-stage view of menopause. In other words, the practitioners' need for concrete, clinical guidelines appears to have outweighed any philosophical qualms associated with the disease model of intervention advocated by the local specialist. Such action is consistent with Lock's (1982: 269-270) argument that the positivist, biological focus of medical knowledge provides the clinician with empirical, clinical evidence which 'because of its direct and immediate nature, is likely to be more compelling...in justifying medical decisions'. Certainly the practitioners appeared firmly convinced of the effectiveness of medical monitoring for possible side-effects associated with hormone treatment and in this way allowed their personal convictions to be outweighed by their professional knowledge.

The most striking outcome of the conflicting and ambiguous state of knowledge was, however, the strategy of informed patient choice of treatment protocols adopted by all the practitioners. This strategy may have been in response to the observation that women do not usually wish to be on medication for longer than necessary and will commonly self-regulate and terminate HRT. However, it nevertheless places the treatment decision with the patient and so raises a number of issues. There is, for example, the question of who ultimately makes the treatment decision. The 'informed' patient or the practitioner, or is it reached through a process of negotiation? Even more significant, is the question of what factors influence the decision reached? Is, for example, the doctor/patient relationship one of equals or does the patient feel intimidated and unable to ask appropriate or important questions? Or is the patient even aware of what she should be asking? More to the point, how skilled is the doctor at clearly conveying accurate information? And, how appropriate

is it for the practitioner to place such a decision on a particular patient? For example, is the patient in a position to fully comprehend the implications of the treatment decision or is she too upset or unwell; does she have or does she lack the necessary education, confidence or language skills; and does she feel vulnerable and/or confused? These (rhetorical) questions challenge the assumption or reality of 'informed' patient choice of treatment protocols. They are questions that stem from the literature on the nature of doctor/patient relationships, especially in the context of a situation where the doctor is recognised and accepted by the patient as the 'professional', the 'expert' or 'authority' with respect to treatment (see Hauser, 1981; Armstrong, 1982; Pappas, 1990; Lupton, 1997).

Although the practice of sending the woman away to consider her options provides her with an opportunity for reflection and discussion with others, there is, nevertheless, an issue of professional accountability at stake. What comes to mind is whether the strategy of informed patient decision-making ultimately relieves the practitioner of both having to make a treatment decision and even professional accountability in the event of a negative outcome. Although the latter is unlikely to be a motivation, it has to be acknowledged that given the ambiguity and confusion surrounding the definition and treatment of menopause, the practice of informed patient decision-making may, at times, present an attractive option or even represent a rejection of 'expert' status. Viewed in another way, it is also clear that all the practitioners had developed long-term professional relationships with a number of their patients. Under such circumstances a patient-led decision may indicate a situation of mutual trust that has developed over a period of time and the practitioner's empathy with the woman's right to make an informed treatment choice.

Finally, contributing to the practitioners' awareness of patient rights is the impact of the 1988 Cartwright Report.<sup>6</sup> Among other things, the Report's emphasis on patient rights and medical ethics has placed front-line health professionals in a particularly invidious position. Aware of the ethical requirement of informed patient choice on treatment decisions and protocols, general practitioners find themselves in a situation where they are 'damned if they

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<sup>6</sup> The Report of the Cervical Cancer Inquiry (Cartwright, 1988) followed months of investigation into the experimental treatment of women with abnormal smears at National Women's Hospital in Auckland. The report made extensive recommendations on the need for reform in medical research protocols, medical ethics and the protection of patients' rights.

do' and 'damned if they don't'. Faced with a combination of knowledge ambiguities and an emphasis on patient's rights, general practitioners walk a tightrope between medicalisation and negligence, and professional dominance and patient choice.

### **THE NATIONAL ADVISORY COMMITTEE REPORT**

The report on hormone replacement therapy produced by the National Advisory Committee on Core Health and Disability Support Services (1993b) was the outcome of a two day consensus development conference hosted by the Core Services Committee under the direction of a project manager. Conference participants were invited professional and lay experts chosen for their individual expertise in the field (the National Advisory Committee on Core Health and Disability Support Services, 1993b:2). The purpose of the conference was to examine the risks and benefits of hormone replacement therapy, recommend the circumstances under which treatment with HRT is the most appropriate option, and identify the most suitable modalities of treatment and information for recommendation to women and health professionals (the National Advisory Committee on Core Health and Disability Support Services, 1993b:5).

The report presented a comprehensive overview of the (then) current state of research on HRT and concluded with fifteen recommendations which addressed the themes of women's rights, clinical assessment, prescribing protocols and guidelines for the use of HRT. Uncertainties and contradictions surrounding the (then) current state of knowledge on menopause and HRT were identified and the point emphasised was that (the National Advisory Committee on Core Health and Disability Support Services, 1993b:Citation: 10):

While a variety of physical and psychological symptoms are commonly attributed to menopause, only vasomotor symptoms (hot flushes) and vaginal symptoms (primarily vaginal dryness) have been shown to be clearly associated with menopause.

The report also drew attention to the success of oestrogen trials in substantially reducing the incidence and intensity of hot flushes but noted the conflicting evidence in relation to mood swings, depression, sexual dysfunction and memory loss. Limitations associated with current research were highlighted and the lack of randomised trials and subject bias associated with research on the long-term effects of HRT were emphasised. The report concluded that 'it is not possible to estimate precisely the size of the true effects of HRT on fracture risk, coronary heart disease and breast cancer risk...and to a lesser extent

endometrial cancer' (the National Advisory Committee Report on Core Health and Disability Support Services, 1993b:17).

The report expressed concern over the quality of available information on HRT, particularly that disseminated by popular magazines and through pharmaceutical companies. It recommended that unbiased, accurate information on menopause and HRT should be available to all women and health care providers. It also adopted a cautious approach to the use of HRT and advocated separate consideration of short- and longer-term use of the treatment. Finally, the report did not recommend the routine and/or long-term use of HRT for well women.

The significance of the report lies with its overview of knowledge on menopause and the formulation of guidelines for the use of HRT among New Zealand women. While no doubt considered by some to be conservative in its recommendations, it nevertheless addresses the majority of queries and uncertainties raised by the general practitioners interviewed in this study. It seemed surprising, therefore, that only Zoe made spontaneous reference to the report and that Warren, the only practitioner directly asked about it, replied that he had 'thumbed through it, but it is quite a thick thing... they brought out one thing after another'. Zoe's reference to the National Advisory Committee Report occurred during a focus group discussion on the risks associated with long-term use of HRT. Zoe asserted in this discussion that 'the Core Services Committee said that [women] are ten times more likely to die of a heart attack without [HRT], than [of] breast cancer [as a result of taking HRT]'. Although her reference to the report was not taken up or pursued by the other practitioners present, this does not mean that they were either unaware of it or had not read it.

Have other practitioners, like Warren, 'thumbed through it' but not had time to read the report? If this is the case, what does this suggest? Warren, for instance, indicated a number of reports produced by the same body and, in common with most of the other practitioners, pointed to the daily bombardment of pharmaceutical company material on HRT. Moreover, each of the practitioners commented on the difficulties associated with keeping abreast of the large volume of new medical publications and indicated that they directed their attention to those complaints commonly encountered in daily practice. It is also possible that the daily

deluge of printed material may have made them sceptical and/or complacent about much of the incoming information. Indeed, the general practitioners indicated a preference for alternative sources of information such as in-service training days, their own professional association material, contact with local specialists and personal clinical experience.

### **DEFICIENCY DISEASE VERSUS NORMAL PROCESS**

The National Advisory Committee on Core Health and Disability Support Services (1993b:5) cautioned that:

...most of the data about the long-term effects of HRT on mortality and serious morbidity are derived from non-randomised studies that may be subject to bias. [As a result] there remains uncertainty about the size of the benefits and risks of treatment.

This statement endorses the perception of ambiguity and uncertainty associated with the symptoms and treatment of menopause held by the general practitioners. Moreover, it raises questions as to the validity of the view of menopause as a deficiency disease.

If the knowledge base is flawed and subject to bias as the Advisory Committee indicates, it underlines a more general issue raised by Oudshoorn (1994:3) who argues that the natural body does not exist as science creates rather than discovers realities. Her view challenges the assumption of the neutrality and objectivity of scientific knowledge and draws attention to the interaction between scientific knowledge, technological development and cultural ideology. In other words, Oudshoorn identifies the direction of scientific investigation and the subsequent revelation of 'truths' as indicative of a particular social and technological climate and so vulnerable to change. Indeed, as Kaufert (1988:331) pointed out, the view of the medical professional has remained 'undisturbed by Foucaultian insights into the nature of its knowledge base and [has] continu[ed] to see medical knowledge as an assembly of proven, timeless, objective facts'.

The comments of the general practitioners indicated that their medical knowledge is infused with both clinical experience and common sense understanding of menopause. They constantly expressed concern and ambivalence over the current state of knowledge (as evident in Warren's reference to the 'grey area' surrounding the optimum duration of treatment with HRT) and frequently drew on clinical experience when making treatment decisions. Moreover, the common sense view of menopause as a normal life-stage, a view

which underpinned the professional orientation of each of the eight practitioners, at times appeared to compound their knowledge uncertainties. This is illustrated by Dr M's comment that some 'doctors see menopause as a deficiency state...and others [see it] as a normal ageing thing...[but] I don't know which of the two [I believe]'. The point is, therefore, that the practitioners identified a disjunction between the realist generation of medical knowledge and its application in the clinical situation. As medical knowledge is received and applied at the level of these general practitioners, its 'proven, timeless, objective' scientific qualities are overlaid with their clinical experiences and common sense views, including normative definitions of the feminine.

Fundamental to feminist arguments is the view that medical research on menopause is shaped by normative definitions of femininity.<sup>7</sup> The 'discovery' of menopause as a deficiency disease, in other words, is underpinned by essentialist notions of women as the progenitors of society whose attractiveness, worth and destiny are fertility dependent (McCrea, 1983:111). Certainly essentialist assumptions of 'femaleness' have been identified as pivotal aspects of hormone research.<sup>8</sup> Originally 'discovered' in Britain in 1905 by Starling, Professor of Physiology at the University College of London, hormones were defined as potent substances or the 'chemical messengers' responsible for the regulation of processes in organisms. Oudshoorn (1994:16) points out that the discovery of hormones precipitated a dramatic paradigmatic shift from 'old physiology based on nervous regulation to new physiology based on chemical regulation'. As a result, scientists were able to conceptualise the functioning and development of organisms in terms of chemical activity and so link sex hormones with the gonads, thereby suggesting 'that they had found the key to understanding what made a man a man and a woman a woman' (Oudshoorn, 1994:16).

Recognition of the ovary as the organ responsible for the production of female sex hormones not only fostered a scientific assumption of the ovary as the seat of femininity, but (Oudshoorn, 1994:19):

...provided the gynecological profession with their own 'paradigm-specific' organ which enabled them to delineate the boundaries between gynecology and obstetrics, the profession that focused primarily on the uterus.

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<sup>7</sup> See, for example, Greer (1992), Barbre (1993), Coney (1993) and Zita (1993).

<sup>8</sup> See Bell (1987), Coney (1993) and Oudshoorn (1994).

Thus the scene was set for not only scientific investigation of ovarian function but the identification of a decline in the production of oestrogen at the end of women's reproductive functioning. Menopause could now be recognised as a state of hormone decline caused through 'ovarian failure'. As a medically treatable condition the process of hormonal decline could be reversed and essential femaleness restored to women through treatment with HRT. Certainly Wilson (1966:64, 93), the outspoken pioneer of oestrogen replacement therapy, was unequivocal in his essentialist view of womanhood. 'The estrogen-rich woman, as a rule, is capable of far more generous and satisfying sexual response than a woman whose femininity suffers from inadequate chemical support.'

Scientific identification of menopause as a deficiency disease caused by ovarian 'failure' has been significant in its consequences for women. It has, for example, promoted a focus on understanding menopause in terms of the cause/effect relationship between ovarian activity and physiologically 'provable' symptoms. The result is a simplistic, reductionist approach that is unable to consider the complexity of interaction between psychosocial forces and physiological functioning. Moreover, it advances a 'flawed woman' ideology on the assumption that ovarian failure and associated hormone deficiency is abnormal when compared with the male ability to maintain sperm production throughout the life span (MacPherson, 1987:57). In addition, the deficiency disease model has generated confusion in the medical literature through the application of HRT as a disease *prevention* strategy as well as its application as a disease *treatment* regime (MacPherson, 1987:60). This point was also noted by the National Advisory Committee on Core Health and Disability Support Services (1993b) as one in need of emphasis to health professionals. Finally, there is the danger of the 'medicalisation' of menopause as a result of its medical management with HRT.

## **THE MEDICALISATION OF MENOPAUSE**

Medicalisation as a process of medical redefinition of physical functioning, health and illness which creates a market for its services, is exemplified in the notion of menopause as a deficiency disease treatable with HRT.<sup>9</sup> Despite the general practitioners' view of

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<sup>9</sup> See Illich (1976), Bell (1987:535) and Lock (1988:43).

menopause as a normal life-stage, several of the characteristics of the process of medicalisation emerge through their comments. Perhaps the most notable is the view of menopause as a health hazard adopted by Zoe and Inga and their promotion of HRT for all women. The monitoring protocols associated with the prescribing of HRT are, as suggested by Wayne, also indicative of the process of medicalisation although the point has been made that the doctor has a professional responsibility to monitor treatment.

Bell (1987:536) argues that within the North American situation the medicalisation of menopause has depended on the 'discovery of a theoretical aetiology...made possible by the paradigm of sex endocrinology'. Once science standardised the treatment of women with artificial hormones, medical specialists eagerly incorporated these protocols into clinical practice. One result was that gynaecology was able to discard its more subjective aspects of physiological assessment and adopt a scientific image based on standardised therapeutic treatment. As a medical speciality, gynaecology not only appeared much safer but the medical authority of gynaecologists was enhanced (Bell, 1987:537). The scene was consequently set for the medical monitoring and management of menopause as a deficiency disease via the administration of HRT. Indeed, Kaufert and McKinlay (1985:129) point out that an important implication of the definition of menopause as a deficiency disease was that 'its treatment with oestrogen was not only legitimate, but became an obligation'.

In view of the above comments, the question that comes to mind is how relevant is the medicalisation argument within the context of the New Zealand medical system? In contrast with North American women, New Zealand women consult their general practitioner in the first instance and specialist referral is only instigated if and when deemed necessary. Although it cannot be claimed that the views of the general practitioners interviewed are representative of all New Zealand doctors, the discussion has identified their unanimous rejection of the deficiency disease model of menopause despite the promotion of HRT by Zoe and Inga. Indeed, the general practitioners' comments highlight knowledge ambiguities and contradictions which challenge the assumed uniformity of the impact of 'scientific discovery' and medical knowledge. On the other hand, some of the general practitioners did recognise and at times adopt the treatment protocols and advice of C, the local specialist.

## SPECIALIST CONSULTANT VIEWS

It is possible to obtain some insight with regard to the views on menopause and its treatment advocated by specialist consultants through examination of the comments of a group of Australasian professionals presented in two audio-educational programmes. Before examining the specialists' comments it needs to be emphasised, however, that the views expressed in each programme are constrained by the purpose and circumstances of the particular presentation. Moreover, having to rely on the expert medical opinion offered in these artefacts, in comparison with my interviews with the general practitioners, I am obviously limited in my ability as a researcher: i) to reveal those factors (including personal experiences and common sense assumptions) which inform their views and practices; and ii) to identify discrepancies between what the specialists say and what they actually do in the clinical situation.

The two audio-programmes examined were freely available in New Zealand at the time of data collection, either directly from their producers or through organisations such as the Family Planning Association and some medical practices. The first programme, produced by Radio New Zealand (Replay Radio) was originally broadcast in 1982. Presented in a documentary format, this programme includes New Zealand women's experiences of menopause and responses to their questions by Dr. John Hutton, at that time a resident specialist at Middlemore Hospital in Auckland. Although now dated in its reference to oestrogen treatment, this programme is significant as a local, non-commercial production and is accompanied by a booklet detailing key aspects of the discussion.<sup>10</sup> The second programme, an Australian production commissioned by Wyeth Pharmaceutical Pty. Ltd. (1992), is also accompanied by a freely available booklet. In this programme a number of specialists are interviewed by two medical experts on the symptoms and treatment of menopause. The panel members were: Dr. Edith Weisberg, Medical Director, Family Planning Association of New South Wales; Dr. Margaret Smith, Director, Menopause Clinic, King Edward Memorial Hospital, Perth; Professor Barry Wren, Director, Centre for the Management of Menopause, Royal Hospital for Women, Paddington, Sydney; and Dr.

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<sup>10</sup> Since this programme was produced in 1982 research has linked oestrogen treatment with a higher risk of endometrial cancer. The current strategy is to prescribe a combination of oestrogen and progesterone unless a woman has undergone a hysterectomy in which case oestrogen alone is deemed to be quite safe.

Margaret Williamson, Endocrinologist, Brisbane. The discussion was hosted by Drs. John D'Arcy and Edith Weisberg of the Family Planning Association of New South Wales.

### **Definition of Menopause and Associated Symptoms**

As illustrated by the following quotes, the focus of both programmes is on the physiological aspects of menopause:

The menopause is the time that the woman has her last menstrual period because the ovaries stop working and stop producing oestrogens.

(Margaret Smith)

Menopause occurs because the ovaries are shrinking and during this time the female hormones are no longer produced regularly.

(John Hutton)

At the menopause [women] lose some of their sex hormones... particularly... that very valuable one, oestrogen.

(Barry Wren)

[The] post-menopausal state [is one] of being oestrogen deficient.

(Edith Wiseberg)

The emphasis placed by these health professionals on the physiological aspects of menopause clearly identifies their biomedical orientation. Among the views presented, only Wiseberg and Smith make fleeting reference to the social implications of menopause. Wiseberg comments that menopause marks a new era in women's lives and so presents opportunities for the re-evaluation of directions and lifestyle. Smith, on the other hand, questions whether 'in fact [menopause] may be thought of as just another stage in a woman's life she has got to get through'. The fact that neither remark was elaborated on or discussed further is consistent with the biomedical focus on menopause as a stage of hormone decline.

### **Recognition of Symptoms**

Hutton expects about 80 per cent of women to have at least some symptoms at menopause. Moreover, he indicates that the experience of symptoms varies and does not necessarily apply to all women with the same intensity:

I think perhaps only one woman in five can go through it and say that 'the change' was no trouble to them. There will be a further third who will have some symptoms such as flushes and sweats and I think there is a further third who are going to be quite troubled in the

menopause in terms of disturbances of sleep, with flushes and sweats, with moodiness and irritability and perhaps dry vagina.

He points out that the past lack of sympathy by doctors towards women complaining of menopause-related symptoms reflected a lack of understanding of the physiological process involved. Accordingly, Hutton urges women to seek medical help in the form of the chemical treatment which is 'now available [as] we do understand more about what is happening at this change of life'. Despite such reassurances, Hutton's comments draw attention to the incomplete state of knowledge on menopause, particularly with respect to the mechanisms involved in the interaction between hormone levels and brain activity.

Wren also notes that about 80 per cent of menopausal women experience hot flushes, with approximately half of these being badly affected while the rest will 'get by without any major problems'. His concern focuses on the impact of hormonal changes on the 'bones and arteries [which] continue to deteriorate at the same rate [among all] women [and not just those]...who have symptoms'. Smith, on the other hand, argues that while only a small percentage of women will have significant symptoms about 80 per cent 'will more or less muddle through'. Her experience with women attending clinics indicates that the most commonly reported symptom is hot flushes which are most frequently associated with sleep disturbance. Other symptoms regularly encountered included mood changes, tiredness, loss of confidence, and vaginal dryness:

...the tiredness is quite a classic thing. Of course there are lots of reasons why people would be tired at this time but unusual tiredness is what we ask about...the vagina over the next few years may become dry and intercourse may be painful and sexual drive seems to go down a bit in some women but it doesn't change in others.

In common with Wren, Smith expresses concern over the changes in women's bones and arteries during menopause: 'there is some initial bone loss...and the arteries also are starting to feel the pinch a little bit too. They are changing a little bit and we believe that hormones cause this.'

### **The Risks and Benefits of Medical Management of Menopause**

The specialists in both programmes displayed an enthusiasm over the medical management of menopause with HRT. It needs to be pointed out, however, that Hutton's views were recorded at a time (1982) when the risks associated with the administration of oestrogen treatment alone were just emerging while the longer-term benefits currently associated with

HRT had yet to be established. Accordingly, Hutton's seemingly more cautious approach to the prescribing of hormone treatment and his acceptance of alternative therapies as beneficial to some women most likely reflects the state of medical knowledge at that time:

I have had many patients come and tell me that [vitamin therapy works for them] and interestingly enough sometimes patients fail on oestrogen and then I am very pleased to hear that they have gone on and tried something else and it has worked.

The significant point here is that despite his recognition of uncertainties associated with the knowledge, Hutton nevertheless emphasised the medical management of menopause through the use of hormone therapy.

As a more recent production, the views of the specialist consultants on the Wyeth programme warrant a more detailed examination. This group of professionals advocate the medical management of menopause beyond the control of short-term symptoms and promote the long-term benefits of HRT for all menopausal women. Smith explained that: 'The so-called 'silent epidemics' of heart attacks and osteoporosis will be largely prevented by HRT, so there are a lot of benefits to the body system in taking hormone replacement therapy.' Although these specialists point out the benefits of lifestyle strategies such as diet, exercise and new interests, they are viewed as complementary to rather than as alternatives to long-term hormone treatment.

Characteristic of the specialists' comments is their conviction concerning the benefits of HRT and their confidence that associated risks can be minimised through careful monitoring. In contrast with the majority of general practitioners, therefore, concern over the long-term use of such treatment does not arise. Smith expresses it this way: 'If you are considering long-term prevention of things like bone density loss and heart attacks then [HRT] may be forever'. Wren is even more specific:

If we look at some of the issues which may arise in...older women we are looking at an increase in osteoporosis, there are multiple fractures of the spine and at least a quarter of a million women in Australia have crush fractures of their spine! There is a tremendous risk of hip fracture... and other parts of the body due to fragile bone tissue. But even more important than that, of course, is the damage which occurs to the cardiovascular system and the problem of arteriosclerosis which can cause myocardial infarction and so many other cardiovascular accidents. Most of these, I think, can be avoided or at least the risk can be reduced considerably.

Wiseberg concurs with Wren and points out that:

There is very definite evidence now that oestrogens are protective of blood vessels and that they will reduce the likelihood of women having heart attacks and strokes after the menopause. They won't stop it entirely but they will reduce the risk so that women who take hormones in fact have a lower risk of getting a fracture of the spine or the hip or any other bone in their body as they get older.

In common with their general practitioner colleagues, the specialists acknowledge that the decision to take HRT must be made by the woman. D'Arcy, for example, reflects:

I think we doctors have to be very aware that when our patients come and ask us for HRT or about it that we just don't hand over a pill. That we look at them in their entirety, holistically, and give them plenty of time to discuss their problem.

However, Smith attributes hesitation among women to negative publicity linking oestrogen with certain cancers:

Unfortunately the negative aspects of [HRT] get the headlines and the frightening thought that oestrogens may cause cancer tends to override all the very great benefits of it. I would like to put it in big headlines and publish it in every paper [that] the benefits of hormone replacement therapy far outweigh the risks and that we should have more women having HRT than presently come along to be treated.

During the discussion on risks associated with HRT, Smith notes that (on the evidence then available) there is only a slight increase in breast cancer among women who have been on hormone treatment for nine years. 'We believe the cancer can be picked up earlier [due to constant checks of women on HRT] and treated more appropriately and therefore the ultimate risk from it should be less.' Wiseberg, however, feels that:

The issue of breast cancer needs to be clarified. There is some evidence to suggest that there is a slightly increased risk of breast cancer in women who are taking HRT for many years. I think there is certainly evidence in these women who do get breast cancer while they are on hormone replacement therapy that their prognosis, their outlook, is much better. I am not sure whether [it is because they are closely monitored] or the hormones really do modify breast cancer because there is similar evidence from the [oral contraceptive] pill.

## **IMPLICATIONS OF THE SPECIALISTS' VIEWS**

In contrast with the life-stage perspective adopted by the general practitioners, the views of the specialists presented above identify menopause as a deficiency disease. Why do the specialists promote the deficiency disease view of menopause and appear to be so confident about the benefits of HRT? In answer to this question it is important to recognise that the specialists' view of menopause as a state of hormone deficiency exemplifies the reductionist, mechanistic nature of the biomedical paradigm upon which clinical practice and research is based. The biomedical paradigm, in essence, demands the recognition of menopause as a

condition treatable in the manner of thyroxin or insulin failure. Moreover, the 'expert' status of the specialist consultant means that in contrast with general practitioners they have undergone more extensive training, seen more menopausal patients and are consulted by those 20 per cent or so of women who experience severe problems at menopause.

In a critical review of the medical literature on menopause, Kaufert (1988:343) identified a prejudice among medical practitioners in favour of clinical studies as a knowledge base. Kaufert argued that as a result the corroborative and descriptive findings of epidemiological and social research are disregarded. She also pointed out that clinical studies on menopause generally involve a patient research population and are, therefore, biased in favour of the abnormal and/or severe experiences of this event. This last point is especially significant given that specialists are more likely to be consulted by those experiencing severe difficulties for whom they implement research-based treatment protocols. In other words, specialist clinical practice approximates the conditions of clinical research. There is a high chance, therefore, of a similar treatment outcome which in turn reinforces the value of research-based knowledge. On these grounds it is hardly surprising that specialist consultants adhere to the view of menopause as a condition of hormone deficiency and that they exhibit such confidence in the ability of medical science to offset the effects of this 'disease'.

## **CONCLUSION**

The purpose of the chapter was to explore the views on menopause and its clinical management held by a group of New Zealand general practitioners and Australasian specialist consultants. The objective was to uncover those factors which inform the practitioners' views given the controversial state of knowledge on the subject and to indicate the implications for both clinical practice and women's perceptions and experience of menopause. The underlying theme of this chapter has been the idea that knowledge is socially constructed and so reflects dominant cultural values and beliefs. It was noted that medical knowledge on menopause embodies normative conceptions of the feminine and is primarily derived from clinical research on the small proportion of women who experience severe problems. The outcome is a situation of ambiguity and confusion surrounding the medical definition of menopause, its symptoms and treatment. Furthermore, there is a

tendency towards a polarisation of views (i.e. menopause as a normal life-stage vs. deficiency disease).

Characteristic of the general practitioners' views was their perception of menopause as a normal stage of the female life-cycle and unanimous rejection of the deficiency disease perspective. Despite their apparently uniform view, however, the general practitioners adopted one of two distinctive consultation strategies. The largest group (six out of eight) emphasised menopause as a social as well as a physiological process and accommodated both aspects in the clinical situation. In contrast, the two remaining practitioners (both of whom saw more women experiencing severe menopause-related problems), although adhering to the life-stage view, also promoted the benefits of HRT for all mid-life women. The specialist consultants, on the other hand, accepted and presented the view of menopause as a hormone deficiency disease that was to be medically managed with HRT in a manner akin to diabetes or thyroid dysfunction.

Influential in the general practitioners' views of menopause and its clinical management were their personal and professional experiences. Characteristic of those who emphasised menopause as both a social and physiological process was limited experience in the management of menopause and an associated confusion and uncertainty regarding the ambiguities surrounding its medical definition and treatment. In the perceived absence of clear guidelines, these practitioners overlaid medical knowledge with personal experience. Moreover, they had developed consultation practices which compensated for the knowledge uncertainties and minimised the possibility of negative treatment outcomes. In contrast, the two women practitioners (Zoe and Inga) had extensive experience in the area of women's health and were primarily consulted by female patients, many of whom Zoe described as 'maybe... the worst cases'. On the basis of clinical experience they were therefore convinced of the benefits of medical management with HRT but in each case left the treatment decision with the woman concerned. According to Zoe, the availability of such treatment allowed her 'the chance to be the great healer'.

In the case of the specialist consultants, their focus on menopause as a state of hormone deficiency and its medical management with HRT can also be understood as a reflection of

professional experience. The point was made that specialist consultants undergo more intensive medical training, are recognised by their colleagues and patients as experts in the field, and are primarily consulted by women experiencing severe problems. In other words, the confidence displayed by these professionals in their ability to successfully diagnose and treat menopausal symptoms is derived from their clinical practice. Indeed, the views of each group of practitioners lend weight to the claim of McKinlay and McKinlay (1973:53) that, 'menopausal symptomology, its origin and treatment, is repeatedly described with no empirical basis other than 'experience''.

## Chapter 4

### A Time of Opportunities?

The body is a site where different meanings compete for reference. This does not deny that the term 'menopause' refers to a bodily event...but it suggests that the meanings of that event, its cultural, historical, and personal interpretations, are dependent on the rhetorical strategies to re/present and interpret all of what it is.

(Zita, 1993:61)

In the previous chapter the views of menopause as a deficiency disease and normal life-stage were identified among a group of medical practitioners. A rejection of the deficiency disease view was identified among the eight general practitioners interviewed and the suggestion was made that there appears to be a tendency towards the polarisation of these perspectives. This observation is explored further in this chapter which examines a selected range of educational material (videos and audiotapes, booklets and pamphlets) and programmes (educational workshops) on menopause, all of which have been produced, published or implemented within the last ten years.

Menopause educational material and programmes are important because they present medical information in lay language aimed at a wide range of women. Moreover, the information provided conveys scientific authority through the presentation of biological 'facts' on the process of menopause, as well as the authority of medical strategies for the management of symptoms. For many women such material is likely to be an important (if not the only) source of 'medical' information on the subject. The printed material, in particular, is normally available free of charge and readily accessible from venues such as doctors' surgeries, chemists and other places promoting women's health. Accordingly, menopause educational material and programmes need to be recognised as an integral aspect of the current knowledge on the subject and are potentially a significant influence on women's perceptions and experience of this event.

This chapter aims to explore representations of menopause as presented in education programmes and printed material. The intention is to contribute to the background

against which women's views and experience will be considered in the following chapters. The chapter is divided into three sections, the first of which involves a content analysis of menopause education workshops, video, audio and printed material. The second section examines the views of the New Zealand Family Planning Association North Island education co-ordinator on the role and function of menopause education programmes offered by the organisation. In the third and final section the reaction of a group of Feilding-Manawatu district women to two educational videos and two audio-tapes on menopause is examined.

### **CONTENT ANALYSIS OF SELECTED EDUCATIONAL MATERIAL**

The purpose of any content analysis is to examine a class of social artefacts in order to compare categories of communication (Babbie, 1992:312). Fundamental in such an analysis is the framework from which the visible or manifest content can be identified and the underlying or latent content assessed. In this section, selected menopause educational programmes and printed material will be explored with the intention of identifying assumptions informing the knowledge and views presented. The framework for analysis of the artefacts constitutes the deficiency disease and life-stage models of menopause. The expectation is that programmes and material produced by medically orientated groups will promote the disease model of menopause whereas independent or lay groups will adhere to the life-stage approach. The educational programmes and material to be examined includes three menopause workshops, two videos and two audio-tapes, and five menopause information booklets. Artefacts have been selected on the basis of their availability in or accessibility from Palmerston North, on the assumption that provincially accessible artefacts are likely to be nationally accessible artefacts.<sup>1</sup>

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<sup>1</sup> Written requests were made to the pharmaceutical companies for information on the date of production and distribution of their material within New Zealand. The only response received was from Novo Nordisk Pty. Ltd., who advised that over two thousand copies of their video had been distributed throughout New Zealand to medical practices and organisations such as the Family Planning Association and that their booklet *Voices of Menopause* was the most popular in the country.

### Three Menopause Workshops

#### 1. *Australasian Menopause Society Workshop*<sup>2</sup>

As the first public meeting of the newly formed New Zealand branch of the Australasian Menopause Society, this event was promoted as an opportunity for women in the Wellington area to find out about menopause.<sup>3</sup> Sponsored by the Dairy Advisory Bureau, the meeting was held from 6 to 9 p.m. in the Concert Chamber of the Wellington Town Hall on 21 February 1996 and attended by over two hundred women. The format involved four presentations by members of a panel of medical specialists adjudicated by television and radio personality, Sharon Crosby. The panel members were: Professor John Hutton, a gynaecologist at the Wellington Menopause Clinic; Dr. Robyn Craven, medical practitioner at the Jean Hailes Foundation, Melbourne;<sup>4</sup> Dr. Anna Fenton, endocrinologist at Auckland Hospital; and Dr. Ruth Highet, sports physician at the Wellington Sports Clinic.

The first speaker, Professor Hutton, outlined female reproductive development and changes at menopause which he defined as 'the period when the ovaries cease to function because they are becoming exhausted of the follicles'. In the second session, Dr. Craven presented an overview of the aims of the Jean Hailes Foundation as a centre for education and research on women's health. Commonly reported symptoms and treatment strategies offered by the clinic were detailed. Included in the latter were HRT treatment regimes as well the experimental use of dietary or phytoestrogens for some women. The benefits of a healthy lifestyle for mid-life women and the need for

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<sup>2</sup> The Australasian Menopause Society is a scientific foundation with more than eight hundred members from scientific, medical, nursing and lay backgrounds. The organisation's prime aim is to 'improve the quality of life of women during and after the menopause' through multidisciplinary research and discussion (personal communication).

<sup>3</sup> The Australasian Menopause Society (originally the Australian Menopause Society) grew from 'an ad hoc menopause meeting...in Sydney, with a small group of interested participants from diverse disciplines throughout Australia' (Wren, 1989). Following bi-annual meetings of the original group the Society was formally founded in 1988 at the Gynaecological Endocrinology Conference in Sydney. Professor Barry Wren was elected the inaugural Chairman. By July 1989 the Society had four hundred members which has since grown to the current eight hundred and forty-seven members, primarily from the medical profession. The aim of the Society is to 'advance knowledge about menopause'. The Society produces a bi-monthly newsletter *Changes* which provides commentaries on current medical developments in the management of menopause.

<sup>4</sup> The Jean Hailes Clinic is associated with Monash University and carries out both menopause consultations and research.

regular medical screening and assessment, particularly for those deemed to be at higher risk from heart disease and osteoporosis, were also addressed.

As an endocrinologist, Dr. Fenton focused on the 'emerging problem' of osteoporosis in post-menopausal women. The physiology and implications of oestrogen decline and associated risk factors were detailed together with the need for replacement therapy when indicated. The last speaker, Dr. Ruth Highet, presented a series of humorous slides promoting the importance of diet and exercise in the health and well-being of older women. The impact of oestrogen decline was stressed by Dr. Highet who strongly advocated the long-term use of HRT among all post-menopausal women as a preventative against osteoporosis and heart disease.

## ***2. New Zealand Family Planning Association Workshop***

The second workshop, one of a series run by the New Zealand Family Planning Association, was held in Palmerston North on the evening of 17 May 1996, from 7 to 9.30pm. The goal was to provide women with accurate information on the physical process of menopause and to discuss mid-life related issues in light of available services and self-help care. Menopause was presented as a positive stage in women's lives.

A distinctive feature of all Family Planning Association workshop formats is the recruitment of small groups of women, preferably drawn from a common organisation. Half of those present at this workshop were from the same workplace. The informal format of a led discussion commenced with the educator, Christine, pointing to menopause as a positive transition involving the end of periods and childbearing for a woman.<sup>5</sup> An overview of the physiological changes at menopause, associated symptoms and the role of hormones in female reproductive processes was presented and discussed. Attention was drawn to the negative impact of disparaging comments and horror stories associated with menopause and the group was invited to identify known symptoms and appropriate self-help remedies. The symptoms included tiredness, sleep disruption, mood changes, forgetfulness, depression, hot flushes,

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<sup>5</sup> New Zealand Family Planning educators are lay people trained for their role by the organisation.

vaginal dryness and incontinence while exercising. Diet, and stress reduction were suggested as remedial or relief strategies. The participants were also presented with relevant pamphlets and taken through an exercise aimed at toning the pelvic floor muscles. The evening concluded with a video produced by the English Family Planning Association detailing the menopause experience of three British women.

### **3. *Women's Health Action Workshop***

The third workshop came to my notice through a national newspaper article about a workshop on *Menopause and HRT* to be held in Auckland on 7 May 1994. The article claimed that 'menopause [is] a hot topic on the women's health scene [and so] like its predecessor [the workshop is] expected to be booked out weeks ahead' (Coney, 1994:D2). Organised by Women's Health Action and sponsored by Healtheries (a health food and diet supplement company), the one and a half hour workshop was attended by approximately eighty women. Conducted by Sandra Coney, a feminist journalist and health consumer advocate, the workshop aimed to inform mid-life women about menopause, the risks and benefits of HRT and about the recommendations of the National Advisory Committee on Core Health and Disability Services (1993b) on the use of HRT.

Coney's informal interactive presentation drew heavily on the arguments and findings in her book, *The Menopause Industry* (Coney, 1993). The discussion began with a critical appraisal of drug company and medical promotion of menopause as a deficiency disease. Coney argued that not only does such a view overlook the benefits associated with the end of menstruation but it promotes the idea of menopause as a health hazard. If the health hazard view was adopted women's reliance on medical and pharmaceutical intervention becomes assured and there is an increased potential for economic gain by drug companies and medical professionals in a world with a rapidly ageing female population.

The 'classic' symptoms of menopause were identified (hot flushes and vaginal dryness) and the lack of scientific verification of additional symptoms was pointed out. Indeed, Coney maintained that some symptoms (such as 'unloved feelings') included in drug company information were drawn from stereotypical views rather than medical

knowledge of middle-aged women and so contributed to the promotion of menopause as a negative event. The discussion also addressed the impact of social and cultural forces on the health and well-being of mid-life women and difficulties associated with ageing in a youth orientated culture. Mention was made, for example, of the pressures on women to conform to an ideal, teenage body shape and the lack of older women as role models in our society.

Coney's discussion on HRT reiterated her opening argument that the advancement of menopause as a deficiency disease is motivated by money rather than health promotion for mid-life women. Critical of much of the clinical research on the effects of HRT, Coney voiced strong concern at the promotion of benefits and the downplaying of associated risks. Examples of flawed research involving the role of HRT in the prevention of osteoporosis and heart disease were detailed and participants cautioned on the dubious benefits of blanket treatment of all women. Coney emphasised the need for women to be well informed on issues associated with the use of HRT and pointed to the recommendations of the National Advisory Committee on Core Health and Disability Services (1993b) report as a valuable knowledge resource. Finally, the benefits of lifestyle adjustments such as diet, exercise and stress reduction were promoted as alternative strategies for the relief of short-term menopausal symptoms and reduction of the risk of osteoporosis and heart disease in later life.

### **Manifest Characteristics of the Three Workshops**

Characteristic of the Australasian Menopause Society workshop was the emphasis on the physiology of menopause, associated symptoms and longer-term health risks. The women attending were urged to adopt a proactive approach through lifestyle change and regular medical monitoring, assessment and treatment. The formal programme of the meeting affirmed the expert/lay relationship between presenters and participants, while the use of medical terminology and research results promoted the scientific validity of information and the professional expertise of each speaker. The result was a view of menopause as a health risk necessitating lifestyle adjustment, medical monitoring and management. In other words, the Australasian Menopause Society workshop adopted and presented a deficiency disease orientation to menopause.

In contrast, the New Zealand Family Planning Association workshop emphasised menopause as a positive time of physical and social change, as well as a time of new opportunities in women's lives. The relaxed and intimate format of small group participation in a led discussion, using lay language, fostered woman-to-woman sharing of ideas and the recognition of menopause as an individually experienced phenomenon. The emphasis was on the promotion of women's ability (when in possession of the right information) to make decisions on the strategies most appropriate to their particular circumstances. In other words, the workshop promoted a view of menopause as a normal stage in women's lives, while at the same time recognising some women will elect or require medical assistance for the management of symptoms.

Characteristic of the Women's Health Action workshop was an informal atmosphere of women sharing information and a feminist orientation to the topic. Fundamental to Coney's perspective was that application of a disease model was anathema to a normal stage in women's reproductive lives. Accordingly, her critique of medical research and drug company activities was designed to alert participants to the medicalisation of menopause and the need for mid-life and older women to assert control over their bodies.

### **Latent Content of the Three Workshops**

The deficiency disease orientation presented at the Australasian Menopause Society workshop urged mid-life women to adopt a proactive approach in the management of their long-term health and well-being. Examined on another level, the deficiency disease view exemplifies the biomedical/positivist perspective as discussed in the literature review. Such a perspective recognises the human body as a mechanistic, dualistic entity, knowable through application of the principles of scientific investigation. The exclusion of the non-tangible promotes a linear, causal view of health and illness which does not require consideration of social, cultural or psychological factors. Thus the logical association of 'ovarian failure' with oestrogen decline which, in turn, is linked with an increased risk of heart disease and osteoporosis, is difficult to refute. Under such circumstances a woman's decision not to avert the possible onset of such diseases flies against the current wisdom of

**Table 4.1 Manifest and latent content of the three menopause workshops**

	<b>Australasian Menopause Association</b>	<b>New Zealand Family Planning</b>	<b>Women's Health Action</b>
<b>MANIFEST CONTENT</b>			
Sponsors	Dairy Advisory Board		Healtheries
Presenter(s)	Medical specialist/consultants	Association educator	Feminist journalist, consumer health advocate
Stated aim of workshop	To provide women in the local area with an opportunity to find out what menopause is about	Raise awareness of the physical process of menopause; provide accurate information; promote self-help care; convey a positive attitude about menopause as a normal life-stage	What is menopause? What are the risks and benefits of HRT and the recommendations of the Core Services Committee
Information offered	Medical definition, management and treatment of menopause	Physical changes at menopause. Symptoms and self-help strategies. Women's experience	Medical and socio-cultural views of menopause. HRT research. Self-help strategies
Information presentation	Adjudicated panel of experts, medical language	Informal women-to-women sharing. Lay language	Informal, woman-to-woman sharing. Lay language
Information emphasis	Menopause as a health hazard	Menopause an individually experienced, positive event	Medicalisation of menopause
Information message	Need for medical management and lifestyle adjustment	Ability of women to take control through access to appropriate information and support	Rejection of the deficiency disease model
Orientation	Deficiency disease	Life-stage	Life-stage
<b>LATENT CONTENT</b>			
Philosophical perspective	Biomedical/positivist	Humanistic/interpretive	Critical/ constructivist
Message	Individual responsibility	Women as self-determining agents	Patriarchal dominance/power

scientific knowledge and places her at apparent risk of dire consequences. Viewed in this way, the latent message of the Australasian Menopause Society workshop is one of *individual responsibility for the maintenance of health and well-being*.

The remaining two workshops displayed similarities in manifest content but differed in their latent message. The emphasis on provision of wide-ranging, accurate information at the New Zealand Family Planning Association workshop drew attention to the individual nature of menopause experience. The focus on individual meaning typifies a humanistic/interpretive orientation which acknowledges reality as subjective, fluid and at best partially knowable through interpretation of meaning. Incorporated in the latter is the notion of agency, that is the determining ability of the individual to create their own world through meaningful action. Consequently, the latent message of the New Zealand Family Planning Association workshop is that of *agency in relation to matters of health and well-being*.

In contrast, the Women's Health Action workshop emphasis on the medicalisation of menopause focuses on social and political power rather than on individual action. The feminist approach adopted by Coney draws attention to the role of social processes in the construction of medical knowledge on menopause. Fundamental to Coney's critical/constructivist view is her acknowledgement of social values, beliefs and knowledge as male dominated and defined. Accordingly, the latent message of the Women's Health Action workshop is that of *patriarchal power and control over matters relating to women's reproductive health*.

### **Video, Audio and Printed Material**

In this section the availability of printed material (booklets) and of transcripts of video and audio programmes makes it possible to quantify as well as describe the manifest content of artefacts.<sup>6</sup> A characteristic of the material discussed is the dominance of drug company productions with only three of the nine artefacts originating from alternative organisations.

#### **Videos**

*A Change for the Better: Menopause and HRT Explained* was produced by Novo Nordisk Pharmaceuticals Ltd., in 1994. The programme offers a visual vignette of a middle-class, mid-life, English woman struggling with daily activities while exhibiting

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<sup>6</sup> In the absence of transcripts such an approach was not possible with the workshop material.

signs of irritability, hot flushes, tiredness and absent mindedness. Consultation is sought with her doctor, medication is prescribed and the woman is seen to regain her good humour and energy, and to enjoy a positive relationship with her partner. The voice-over narration presents a range of information which, with the aid of diagrams and charts, discusses physiological changes and symptoms, the benefits of HRT and prevalent social attitudes. The film concludes with a demonstration of the correct way to operate a Kliogest disk dispenser.<sup>7</sup>

*A Change of Life* was produced in Australia for Ciba-Giegy N.Z. Ltd., by Dr. Alistair MacLennan, the then president of the Australian Menopause Society.<sup>8</sup> The programme is introduced by the head of the pharmaceutical division of Ciba-Giegy New Zealand, Nigel Andrews, who indicates that the aim of the programme is 'to explain the changes in a woman's body that cause menopause; the symptoms and effects on women and steps that can be taken to minimise effects'.

A distinctive feature of the video is the use of the first-hand experience of six Australian women as a springboard for conveying information. Changes, symptoms and social pressures described by the women are explored and management strategies are discussed. In particular, the benefits of HRT for the management of symptoms and the promotion of long-term general health and well-being are established. In the final section of the video the six women present a series of questions to a panel of medical professionals (a general practitioner, a gynaecologist and an endocrinologist). The programme ends (as it began) with 'information' on the company's hormone replacement products.

### ***Audio-tapes***

The first of the two audio-tapes, *Presenting a Positive Outlook on the Menopause*, was produced for Wyeth Pharmaceuticals Pty. Ltd., in 1992.<sup>9</sup> In this programme information on menopause is presented by a panel of Australian medical specialists

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<sup>7</sup> The HRT trade name of the Novo Nordisk product.

<sup>8</sup> The actual production date is unknown but it appears to have been around 1990.

<sup>9</sup> Both tapes examined are those from which the views of the specialist consultants were obtained in the previous chapter.

chaired by Dr Barry Wren, Director of the Centre for the Management of Menopause, Sydney. The programme aims to 'present medical options for management and treatment of menopause' and to 'get hormones into perspective'. The discussion details the physiology of menopause and associated symptoms, health risks associated with oestrogen deficiency, and the benefits of HRT and lifestyle factors for the short- and longer-term health of all mid-life women.

The second tape, *Menopause: A Period of Change for Women*, is an edited version of a nationwide talk-back programme conducted by Radio New Zealand in 1982. The programme aims to provide women with the 'facts about menopause' through the responses of a gynaecologist and Family Planning educator to issues raised by women listeners. The focus is on women's experiences of menopausal symptoms and available strategies for symptom relief through either self-help remedies or medical intervention.

### **Booklets**

*Voices of the Menopause* was produced by the Danish headquarters of Novo Nordisk Pharmaceuticals Ltd., in conjunction with Dr. Helen Roberts.<sup>10</sup> The booklet aims to answer questions women may have about health care options and risks associated with mid-life. The format involves a series of responses to women's questions on menopause based on interviews conducted in Europe and the USA. A number of similarities to the company video (*A Change for the Better, Menopause and HRT Explained*) are apparent in the text, graphics and emphasis of the publication. The topics covered in the discussion include the physiology and symptoms of menopause, health risks associated with oestrogen deficiency and the benefits of HRT.

*Living Through Change*, produced by Ciba-Giegy, aims to 'explain the hormonal, physical and emotional changes that occur in a woman's body during the years around menopause' (Ciba-Giegy, n.d:1). The booklet addresses a number of issues under a series of topic headings relating to the physiology and symptoms of menopause, health benefits associated with HRT, and social issues at mid-life. Incorporated in the text are

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<sup>10</sup> Dr. Roberts, a Senior Lecturer in Women's Health, University of Auckland Medical School, and New Zealand Family Planning Association Menopause Clinic practitioner, checked the information for accuracy before release in New Zealand (personal communication).

some of the diagrams and an edited version of the panel's responses to the women's questions presented in the Company's video, *Change of Life*.

*Understanding Menopause* was 'developed in association with experts involved with the treatment of menopause...as an information service for women'.<sup>11</sup> The booklet, produced by 3M Pharmaceuticals with the 'assistance of Dr. Anna Fenton, of the Mercy Specialists Centre, Auckland, and Ailsa Spicer, menopause educator', provides information under a series of nine topic headings. Details of physiological changes, symptoms and health risks associated with menopause, in addition to advice on self-help strategies, medical consultation and New Zealand Family Planning Association resources, are presented. In the final section information on the use and benefits of HRT is accompanied by a series of questions and answers.

*Menopause: A Period of Change for Women* (1988) was produced by Radio New Zealand to accompany the Replay Radio programme of the same name. The edited transcripts of the original talk-back show are organised under a series of topic headings and convey the same themes and information. As with the Replay Radio audio-tape, a unique feature of this publication is the spontaneous commentary of New Zealand women on their experiences and questions about menopause. Indeed, both programmes, together with the Department of Health pamphlet discussed below, are distinctive as non-commercial, completely New Zealand produced artefacts available on menopause.

The final publication to be examined, the pamphlet *Menopause*, was issued by the New Zealand Department of Health (1991) as part of the 'Health Facts' series. Describing menopause as a 'time of change' and a normal process in a woman's life, the double paged pamphlet presents key points on a number of issues including body changes and symptoms, feelings and self-care, and seeking medical advice. A feature of the pamphlet is the inclusion of relevant quotes by women on their experiences. Sources of further information are provided.

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<sup>11</sup> Date of publication and page numbers are not provided in this booklet.

### Manifest Characteristics of the Videos, Audio-tapes and Printed Material

The images and messages presented by these artefacts can be analysed in a number of ways and a range of messages relating to mid-life women and menopause can be identified. For example, the opening sequence in the Ciba-Giegy video features a very slim, young woman in sexy underwear in the process of attaching the company's *Estroderm* patch to her thigh.<sup>12</sup> The none too subtle message is that of an association between the use of HRT and retention of youth, beauty and sexuality. Such messages while both significant and interesting are, however, outside the scope of the present discussion where the focus is on the orientation to menopause promoted by the educational material examined.

**Table 4.2 Key words and their categorisation manifest in videos, audio-tapes and printed material<sup>13</sup>**

Physiology	Symptoms	Lifestyle
HRT/ERT*	heart/cardiovascular	vitamins
hormones	osteoporosis	calcium
progesterone	bones	diet
oestrogen	vaginal dryness	exercise
ovaries	hot flushes/night sweats	
periods	sleep disruption	
	tiredness	
	irritability	
	moodiness	
	depression	
	palpitations	
	memory impairment	
	loss of confidence	

\*Oestrogen replacement therapy

Examination of the manifest content of each transcript and text reveals the common use of words which can be classified into three categories, namely: the physiology of menopause, for example, hormones; symptoms associated with menopause, for example, heart/cardiovascular deterioration; and lifestyle adjustment/change, for example, vitamins. For a complete list of key words under each category see Table 4.2.

<sup>12</sup> 'Estroderm' is the trade name of the Ciba-Giegy hormone patch.

<sup>13</sup> The key words were identified through examination of the artefacts.

**Table 4.3 Deficiency disease and life-stage classification of key words**

<b>D E F I C I E N C Y</b>	<b>Physiology I</b>	<b>Symptoms</b>	<b>Lifestyle</b>	
	HRT/ERT*	long-term		
	hormones	heart/cardiovascular		
	progesterone	osteoporosis		
	oestrogen	bones		
<b>D I S E A S E</b>	<b>Physiology II</b>	vaginal dryness	vitamins	<b>L I F E  S T A G E</b>
	ovaries		calcium	
	periods	<b>Short-term</b>	diet	
		hot flushes/night sweats	exercise	
		sleep disruption		
		tiredness		
		irritability		
		moodiness		
		depression		
	palpitations			
	memory impairment			

\*oestrogen replacement therapy

Further scrutiny of the categories of key words reveals a distinction between long- and short-term symptoms. The point is that long-term symptoms are those associated with oestrogen deficiency, a view characteristic of a disease orientation to menopause. In contrast, a lack of scientific verification of the majority of short-term symptoms (apart from hot flushes/night sweats) relegates them to the realm of the subjective and psychosocial, characteristic of a life-stage orientation to menopause. Taken one step further it becomes apparent that artefacts promoting a deficiency disease orientation will emphasise the physiology of menopause and long-term symptoms whereas a life-stage orientation will focus on lifestyle factors and short-term symptoms. The matter is not, however, completely clear cut as examination of the frequency of key word use among the artefacts (see Tables 4.4 and 4.5) reveals a degree of overlap with respect to the words 'ovaries' and 'periods' (physiology), 'vaginal dryness' and 'hot flushes' (scientifically verified symptoms), and 'vitamins', 'calcium', 'diet' and 'exercise' (lifestyle factors). In other words, key words located in the deeper shaded band in Table 4.3 are common to both orientations (i.e. deficiency disease and life-stage) and

are only indicative of the orientation of an artefact in conjunction with key words in the other two categories (indicated by lighter shading).

In sum, Table 4.3 indicates that artefacts presenting a deficiency disease orientation to menopause will display a higher word use frequency in the categories of physiology (I and II), long-term symptoms plus hot flushes/night sweats and lifestyle, and exhibit a lower word use frequency in the short-term symptom category (excluding hot flushes). On the other hand, word use frequency in the categories of short-term symptoms plus vaginal dryness, lifestyle and physiology (II) will characterise a life-stage orientation.

**Table 4.4 Key word frequency: videos and audio-tapes**

	Novo N video	Ciba-G video	Wyeth	RR audio
<b>Physiology</b>				
hormones	8	24	23	6
HRT/ERT	21	31	35	1
progesterone	8	7	1	nil
oestrogen	19	27	28	13
ovaries	3	12	2	5
periods	7	6	3	9
<b>Symptoms</b>				
heart/cardiovascular	8	6	22	nil
osteoporosis	8	14	18	nil
bones	6	13	20	1
vaginal dryness	3	3	2	9
hot flush/night sweats	3	10	6	62
sleep disruption	1	3	2	5
tiredness	1	1	5	1
irritability	1	nil	1	8
moodiness	1	4	3	3
depression	nil	4	nil	9
palpitations	1	1	nil	2
memory impairment	1	1	nil	3
confidence	nil	nil	1	2
<b>Lifestyle</b>				
vitamins	nil	nil	1	12
calcium	nil	11	21	1
diet	nil	1	13	2
exercise	1	3	13	3

Tables 4.4 and 4.5 quantify the word use frequency for each artefact according to the categorisation presented in Table 4.3. Conversion of figures presented in Tables 4.4 and 4.5 into percentages allows the orientation of each artefact to be established. In other words, those artefacts expected to adopt a deficiency disease orientation will

**Table 4.5 Key word frequency: booklets and pamphlets**

	Novo Nordisk booklet	Ciba-Giegy booklet	3M booklet	Replay Radio booklet	Health Dept. pamphlet
<b>Physiology</b>					
hormones	9	27	12	4	2
HRT/ERT	25	26	59	3	1
progesterone	18	11	7	2	1
oestrogen	26	24	44	20	6
ovaries	4	7	7	7	1
periods	11	9	15	16	14
<b>Symptoms</b>					
heart/cardiovascular	2	5	21	nil	nil
osteoporosis	18	7	24	2	nil
bones	17	8	40	2	nil
vaginal dryness	7	5	6	7	5
hot flushes, night sweats	2	14	14	21	12
sleep disruption	1	2	3	3	nil
tiredness	1	3	2	1	nil
irritability	1	1	3	4	1
moodiness	11	nil	6	1	nil
depression	2	3	4	1	nil
palpitations	nil	nil	2	2	nil
memory impairment	1	nil	1	2	nil
confidence	nil	nil	nil	2	nil
<b>Lifestyle</b>					
vitamins	nil	nil	13	23	2
calcium	nil	9	23	6	nil
diet	1	5	5	3	1
exercise	1	7	11	3	2

score a high percentage for words categorised as physiology I and II, long-term symptoms and lifestyle, and a low percentage in the category of short-term symptoms (apart from hot flushes/night sweats). Conversely, life-stage oriented artefacts will score a low percentage of word use in physiology I and long-term symptoms (apart from vaginal dryness) but a high percentage of word use in the categories of physiology II, short-term symptoms and lifestyle.

The results of the key word percentage calculations reveal a high percentage in the deficiency disease categories for each of the artefacts produced by pharmaceutical companies: Novo Nordisk video, 94 per cent; Ciba-Giegy video, 92 per cent; Wyeth audio-tape, 94 per cent; Novo Nordisk booklet, 89 per cent; Ciba-Giegy booklet, 95 per cent, and 3M booklet, 93 per cent. In contrast, key word percentages for the independently produced artefacts indicate a reverse trend with a high percentage in the life-stage categories: Replay Radio audio-tape, 86 per cent; Replay Radio booklet, 76

per cent; and Health Department pamphlet, 79 per cent. In other words, quantification of word use frequency establishes that the pharmaceutical company artefacts promote a deficiency disease orientation to menopause whereas the independently produced material advances a life-stage orientation.

### **Latent Content of Videos, Audio-tapes and Printed Material**

In common with material presented at the Australasian Menopause Society workshop, the deficiency disease orientation in drug company material is dependent on the credibility and authority of scientific knowledge. Women seeking information and help from such material are confronted with a range of scientifically verified 'facts' that appear to be unbiased, credible and indisputable. What is not apparent, however, is the context from within which the knowledge on menopause has emerged. For example, critics point out that this biomedical knowledge 'is primarily based on a small proportion of self-selecting, predominantly ill women' (McKinlay et al., 1987:110) on the assumption that they are representative of all women. Moreover, references to the controversial nature of claims associated with the benefits and risks of HRT are either non-existent or downplayed in the drug company material, while calculations of the number of women at high risk from the long-term effects of oestrogen deficiency have been challenged as inflated (see Coney, 1993; Voda, 1993).

In other words, the deficiency disease orientation adopted by the pharmaceutical companies exhibits both a manifest and latent bias in favour of the benefits of HRT, motivated by a large potential market associated with the age of 'meno-boomers'.<sup>14</sup> As in the case of the Australasian Menopause Society workshop, the outcome is the medicalisation of menopause via the latent message of a need for individual responsibility and proactive action given the scientifically established long-term health risks associated with oestrogen deficiency.

The manifest content of the life-stage artefacts identifies short-term symptoms, cessation of periods and ovarian functioning, and lifestyle strategies as areas of

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<sup>14</sup> The term 'meno-boomers' refers to the ageing post-World War II baby boom generation (Barbre, 1993:23)

immediate concern to mid-life women. That is, the focus is on what is subjectively tangible and knowable through embodied experience, rather than on what is medically objective and knowable through scientific verification. Underlying the life-stage orientation is an emphasis on the individuality of experience within a wide range of normal as opposed to the deficiency disease assumption of uniformity of experience based on clinical pathology. Furthermore, the strategy of shared information emanating from statements of personal experience manifest in the life-stage artefacts, conveys a spirit of sisterhood, group identity and knowledge credibility. In other words, the life-stage artefacts affirm a woman's individual experience and ability to implement the choices she considers most appropriate to her circumstances. This affirmation of a woman's experience is in stark contrast to the power dynamic underlying the deficiency disease orientation, where failure to heed scientific evidence of the risks of oestrogen deficiency is deemed irresponsible. In short, the latent message of the life-stage artefacts is one of validation of the individuality of women's experiences at mid-life and affirmation of their ability to engage in appropriate health promotion strategies.

### **NEW ZEALAND FAMILY PLANNING ASSOCIATION, MENOPAUSE EDUCATION**

Education and information on menopause is part of the work on women's sexual and reproductive health undertaken by the twelve New Zealand Family Planning Association education units located throughout the country. On 12 April 1996, I met with Margaret Durdin, the North Island Education Co-ordinator, at the Wellington headquarters of the Association. My purpose was to find out about the Association's programmes on menopause - their role and aims, the views promoted, and the type of information typically sought by clients.

During the ninety minute meeting, Margaret explained that underlying the Association's approach to menopause education is an emphasis on a 'balanced', 'holistic' view which incorporates consideration of 'all the issues' relevant to women at that particular time in their lives. The Association's aim is to provide a range of information (including recent and ongoing research) as a response to women's concerns, while at the same time avoiding detail requiring personal and/or professional assessment:

...we work from where the women are at and get all that information [to them] because they are the only ones who know what really has worked for them.

The objective, therefore, is to present women with a range of choices from which informed decisions can be made.

The New Zealand Family Planning Association offers a telephone service, a range of printed information and clinical consultations to mid-life women. The key area of menopause education, however, is the organisation of discussion groups within local communities such as Palmerston North. The usual strategy is to recruit women from a single organisation (e.g. a factory) so that they will be familiar with each other, relaxed and comfortable while discussing menopause and mid-life related issues. Margaret explained that 'the purpose of [the] workshops is to get women talking, thinking [and] being helped to make decisions' about mid-life matters as well as the management of menopause-related symptoms:

...we like to look at the things that are happening in [the women's] lives....To see menopause as a time [in] the middle of your life...for re-evaluating what you do.

Family Planning discussion groups follow a set format with a standard outline of topics. If participants indicate an interest in the topic of HRT then the most recent research is detailed, possible benefits are discussed and aspects that should be checked out with a woman's general practitioner are identified. The educator may also show the group a drug company video so that promoter bias can be examined and the women made aware of both the benefits and risks associated with such treatment.

Of paramount importance to each group discussion are the thoughts and feelings of the women attending. As Margaret put it:

We would like to know what [the women's] first thoughts are...either from the experience they have already had or what they have heard. What they are guessing? They can say whatever that is...you then get a whole range of feelings because a lot of menopause is about feelings, about yourself or about your expectations.

An attempt is made to dispel myths and popular stereotypes surrounding menopause and mid-life women. For example:

...one of the myths we want to debunk is that 'it's your hormones! Oh, she's going through the change!' Women could get put down by that, [they] could get genuine feelings actually wiped out [or] diminished.

Similarly, awareness of the use of negative language associated with certain aspects of the physical process of menopause is promoted. Margaret explained that:

Ovarian failure is my latest mission. What on earth does ovarian failure mean? An ovary is an ovary! It cannot fail. It is still an ovary! What you mean is that it is not releasing eggs in the way it used to do before.

In such ways the Association attempts to discredit the negative and reinforce the positive message that mid-life and menopause are not dreadful events over which women have no control. Rather they are promoted as 'a positive time [which] gives [a woman] an opportunity to look at her life [in a new way]'. Women are accordingly encouraged to take stock of possible new directions at mid-life and in particular to examine their role as nurturers.

To sum up, the discussion with Margaret Durdin established that a holistic view of mid-life and menopause is fundamental to New Zealand Family Planning Association education programmes. The aim is to present information that enables women to implement strategies based on informed decisions appropriate to their particular circumstances. That is, the Association's education programmes are about recognising and promoting the worth of mid-life women, their right to have and express feelings, and their ability to take control and so enjoy life satisfaction and general well-being at mid-life and beyond.

## **RESPONSES TO SELECTED VIDEOS AND AUDIO-TAPES**

In the preceding sections of this chapter attention has been drawn to the apparent dominance of drug company artefacts promoting both a deficiency disease orientation and a message of individual responsibility which in effect advances the medicalisation of menopause. In order to explore the impact of the promotion of the deficiency disease model in the educational material on menopause the responses of a group of women to four of the artefacts discussed earlier are examined. The objective was to establish whether or not the women reached the same conclusion as myself regarding the orientation of each programme, and how they viewed the information offered in light of the dominance of a deficiency disease orientation.

The women's views were obtained in two ways: first, through a focus group meeting where two videos were shown; and second, through written responses to an audio-tape sent out by mail. Women from Feilding and the Manawatu district were recruited for this exercise from among those who had participated in earlier focus groups and who were still available. Among the six who participated in the focus group, two (aged in their late thirties and early forties respectively) had yet to reach menopause while the remainder (aged fifty and above) classified themselves as 'in' or 'through' menopause. Of the twelve who completed the mail questionnaire, six were in their thirties and had yet to reach menopause, while the remainder (aged fifty and upwards) all classified themselves as 'through' menopause.

All the women completed a brief questionnaire in which they indicated the emphasis they perceived to be placed on key concepts by each programme as well as responding to a more general set of questions.<sup>15</sup> Six women were present at the focus group where the videos *Change of Life* (Ciba-Giegy) and *A Change for the Better: Menopause and HRT Explained* (Novo Nordisk) were shown. Seven responded by mail to the *Menopause: Period of Change* (Replay Radio) audio-tape while five responded by mail to the audio-tape *Presenting a Positive Outlook on the Menopause* (Wyeth Pharmaceuticals). Given the small numbers of women involved, the discussion will examine the overall pattern of responses rather than attempt to quantify the results.

None of the six women who met at the Feilding Community Learning Centre to view the Ciba-Giegy and Novo Nordisk videos had seen either programme before. Differences emerged between the views expressed by the three group members currently taking HRT and the remainder who declared their philosophical opposition to such treatment. Indeed, the divergence of views was such that at one point the women on HRT appeared to be uncomfortable at the turn of the discussion, a situation quickly detected and rectified within the group itself through comments such as: 'You all look very well'. 'You are all an advertisement for the product'.

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<sup>15</sup> See Appendix 6.

In response to a question as to whether or not the group felt better informed for having seen the two video programmes, one of the three women taking HRT commented that she 'knew all that!' The remaining two HRT users, however, expressed enthusiasm for the content of both programmes. They felt better informed on issues not covered by their doctors and, in the case of the Ciba-Giegy video, by the presentation of women's experiences similar to their own. Barbara\* (aged 57),<sup>16</sup> for example, remarked:

...that's something I picked up...when they put me onto HRT I thought, 'Oh golly I won't miss a pill'! I am really strict about that but [the general practitioner on the Ciba-Giegy programme] said it didn't matter if you missed it [occasionally].

On the other hand, the remaining three women not on HRT (two of whom had yet to reach menopause) adopted a more critical stance towards the information presented in each video. They expressed concern at the emphasis placed on HRT and the downplaying of associated risks, especially breast cancer. They also felt that the deficiency disease view emphasised by each programme presented menopause as an illness in all women. Anne\* (aged 42), in particular, expressed alarm over what she perceived as the political implications of the promotion of menopause as a deficiency disease:

...my concern is that women will be more or less forced to go on [HRT] because of the so-called long-term consequences of getting old and [the association with] osteoporosis and cardiovascular disease that's now being pushed. So whether you need to [go on HRT] or not, they will push the long-term stuff rather than relief for symptoms...because you are going to be a cost to the [health care] system down the track [if] you are going to have heart trouble or hip fractures.

Overall, the group response to each programme was characterised by a focus on the information presented on HRT despite each programme's stated aim of educating women on the physical process of menopause. The women noted the emphasis placed on the management of menopause through the use of HRT and felt that information on alternative or complementary management strategies could have been presented. They were also aware that menopause is not always problematic and felt that a focus on the 'normal' as well as the 'difficult' would have provided a more balanced view of women's experiences. In fact there was general agreement among the group on the need for independently produced educational material which would present 'a more

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<sup>16</sup> The reader is reminded that the asterisk after a woman's name identifies her as a Feilding-Manawatu district participant.

balanced and rounded view [by] bringing in women's experience [and] self-help and alternative [management strategies]...in addition [to] the medical model'.

Among the Wyeth and Replay Radio audio-tape listeners the majority indicated that they felt better informed having heard the particular audio-tape mailed to them. Characteristic of the response of each group of listeners was an emphasis on the orientation presented by the audio-tape. In the case of the Wyeth tape the women's comments were primarily concerned with the issues of oestrogen, its impact on the body and the role of HRT at menopause. The information was generally accepted enthusiastically and uncritically. On the other hand, the Replay Radio listeners focused on the benefits of insight into other women's experiences and the ability of women to 'take control' through self-help and lifestyle strategies. The members of this group were, however, critical about the lack of material on the long-term physiological effects of menopause and issues associated with the use of HRT. Overall, both groups of women expressed general satisfaction with the quality and range of information presented by each audio-tape and unanimously indicated that they would recommend their particular audio-tape to other women.

In addition to the responses discussed above, the women indicated the degree of emphasis they perceived to be placed by each of the two videos watched (in the focus group meeting) and the particular audio-tape received by mail on each of the items or topics listed in Table 4.6.

**Table 4.6 Programme emphasis on aspects of menopause**

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The physical changes that occur in a woman's body at menopause
Vaginal dryness, hot flushes and night sweats as common symptoms
Tiredness, sleep disruption, mood swings, depression as common symptoms
Osteoporosis in post-menopausal women
Cardiovascular disease in post-menopausal women
The role of diet and exercise in the prevention of osteoporosis
The use of vitamins and alternative strategies to reduce the impact of menopausal symptoms
Women's views on their experience at menopause
Menopause as a normal stage of a woman's life-cycle
Benefits associated with the use of HRT
Menopause as a hormone deficiency disease
Risks associated with the use of HRT
The benefit of HRT for all women
The need for all women to see their doctor during the menopause
Women's own (non-medical) strategies for coping with menopause and its symptoms

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All four programmes (the two videos and the two audio-tapes) were identified as placing a high degree of emphasis on: the physical changes that occur in a woman's body at menopause; the benefits and risks associated with the use of HRT; symptoms of vaginal dryness, hot flushes and night sweats; and the need for all women to see their doctor during the menopause. In addition, the programmes produced by the pharmaceutical companies (Ciba-Giegy, Novo Nordisk and Wyeth) were identified as placing a high degree of emphasis on the symptoms of osteoporosis and cardiovascular disease in post-menopausal women. The Replay Radio and Wyeth audio-programmes were perceived to place considerable emphasis on: diet and exercise; vitamins and alternative strategies; tiredness, sleep disruption, mood swings and depression as common symptoms; and women's strategies for coping with such symptoms. Finally, the Replay Radio and Ciba-Giegy programmes were seen to place a high degree of emphasis on women's views on their experience at menopause.

In sum, the women's perceptions of the emphasis placed on particular items or topics in each programme approximated the findings presented in Table 4.3. All three drug company produced programmes were perceived to place a heavy emphasis on menopause as a deficiency disease, whereas the Replay Radio audio-tape was seen to emphasise menopause as a normal life-stage. What was surprising, however, was the women's perception of the Novo Nordisk and Wyeth programmes as presenting *both* a life-stage *and* a deficiency disease orientation. Viewed in the context of their overall responses, however, this perception was consistent with an apparent expectation that both perspectives would be included in educational material on menopause. For example, with respect to the two videos the discussion group pointed to the need for 'more balanced' information which included the 'normal' (as well as the 'difficult') experience of women. Similarly, the Replay Radio audio-tape was seen as lacking sufficient information on physiological changes and HRT. It could be concluded, therefore, that the Novo Nordisk and Wyeth programmes came closest to presenting the type of information expected by the women assessing the programmes.

If the above conclusion is accepted the question that arises is why do the women perceive *both* orientations (i.e. deficiency disease *and* life-stage) in two programmes which have been identified in the earlier content analysis as exhibiting a 94 per cent

deficiency disease key word use? The answer seems to lie in the fact that their juxtaposition of orientations mirrors the general practitioners' overlaying of medical knowledge with common sense views of menopause. In this instance, the women's responses to the educational programmes indicate the impact of medicalisation. The deficiency disease view has been incorporated in their common sense view of menopause so that their life-stage view is mediated by common sense knowledge of hormonal changes as underlying the menopausal experience. Consequently, there is an expectation by the women that menopause educational material will feature *both* a deficiency disease *and* a life-stage orientation. It might also be suggested that their understanding and expectation provides a common basis for informed decision-making and treatment negotiation between the women on the one hand and general practitioners (such as those interviewed for this study) on the other.

The women's expectation that menopause educational material would or should feature both experiential and pathological material on menopause raises a number of issues which will be explored in the following chapters. The most obvious issue concerns the social context within which the deficiency disease view of menopause is being presented. What other common sense views of menopause exist and what are their sources? Do New Zealand women, for example, share their experiences of menopause or is it regarded as a personal and private event to be endured without mention or complaint? If so, is common sense knowledge derived primarily from observation and supposition? Does this also indicate that the sharing of experience and understandings of menopause is constrained by a climate of taboo? If there is a climate of taboo, have aspects of the deficiency disease model of menopause become internalised and re-emerged as common sense knowledge? If this is the case, they are likely to expect a pathological or deficiency disease orientation to menopause such as that presented by some of the educational programmes.

## CONCLUSION

The aim of this chapter has been to add to the background (see also Chapter 3) against which the knowledge, expectations and experience of menopause among New Zealand women can be explored. The discussion has focused on the manifest and latent content of educational workshops and widely available video, audio and printed material. It

was found that the programmes and materials produced by medically orientated organisations primarily presented a deficiency disease orientation whereas those produced by 'independent' groups or organisations primarily presented a life-stage approach.

Among the deficiency disease orientated programmes a latent message of individual responsibility for health and well-being was identified. In contrast, life-stage orientated material emphasised the worth of mid-life women and aimed to assist them to take on new directions and exercise control over their lives. With the exception of the Women's Health Action workshop, these artefacts promoted the notion of agency (the ability of the individual to create their own world through meaningful action) in relation to women's reproductive health and general well-being. In the case of the Women's Health Action workshop, the message of patriarchal power and control over matters relating to women's reproductive health was identified.

An exploration of the views of the New Zealand Family Planning Association's Educational Co-ordinator (North Island) identified a holistic approach for the Association's involvement in menopause education. A message of agency was apparent in the focus and direction of the programme material which aimed to promote the worth of mid-life women, to assist them to take on new directions and to exercise control over their lives.

Finally, the perceptions and responses of a group of Feilding-Manawatu district women to four of the educational programmes were examined. Their perceptions of the items/topics emphasised in the programmes generally corresponded with the findings of the earlier content analysis. However, their juxtaposition of orientations in the case of two of the programmes was interpreted as an indication of the incorporation of a pathological (i.e. deficiency disease) understanding of menopause into their common sense view of this event. In short, the women's perceptions and responses appeared to indicate a partial medicalisation of menopause involving the understanding of physical experience in terms of hormonal activity. Overall, the findings presented in this chapter (as well as Chapter 3) provide the background and

points of reference for the following discussion of the women's knowledge, expectations and experience of menopause.

## Chapter 5

### Knowledge and Taboo

About pregnancy we are taught everything one could want to know. By contrast, I went into menopause knowing nothing - not even that I was in it. But in trying to learn or talk about menopause, I found myself up against a powerful and mysterious taboo. My friends were adrift in the same fog of inexcusable ignorance. We couldn't help one another because none of us knew enough.

(Sheehy, 1993: vii)

Although Sheehy's reference to a taboo refers to the North American situation it nevertheless raises the question as to whether a similar situation exists within New Zealand. With this question in mind, this chapter seeks to identify sources of knowledge and to examine their impact on women's perceptions of menopause. The discussion commences with an examination of mother/daughter and woman-to-woman communication on menopause and related aspects of female sexuality. The focus then shifts to other knowledge sources, the women's assessment of their personal knowledge status and their perception of the availability and quality of information.

An important issue here concerns the distinction between knowledge and belief.<sup>1</sup> For the purposes of this discussion, belief may be broadly defined as any proposition which is viewed as valid and meaningful (Good, 1994:19), whereas knowledge may be understood as comprising beliefs or understandings that have not been refuted by systematic, rigorous investigation or the repeated 'trial and error' of human experience. In this respect, Kemm (1991) argues that in the context of health information, differences in professional interests, epidemiological evidence and clinical opinion result in the blurring of knowledge with belief. Although health professionals (Kemm, 1991:292):

...usually distinguish sharply between knowledge or 'facts' and other categories of belief... They may variously describe their knowledge as 'accepted scientific knowledge', 'prevailing common sense knowledge' or 'individual knowledge based on experience'.

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<sup>1</sup> There is a vast body of literature on the subject of knowledge and belief, the examination of which is beyond the scope of this thesis. For a discussion of its relevance to anthropological research, see Good (1994).

Kemm (1991:295) also makes the point that: 'Much of what is generally called the 'knowledge' base of health promotion would be better described as best available opinion'. In other words, there is a tendency for health professionals to mix medical knowledge with common sense knowledge and experience, a tendency that has already been identified in Chapter 3 with respect to the general practitioners in this study (although they too appeared to maintain a general distinction between knowledge and belief). Does a similar tendency to mix common sense belief, experience and medical knowledge occur among women in this study? If so, is it a tendency associated with the process of medicalisation? Answers to these questions will emerge in the course of this chapter.

### **MOTHERS AND DAUGHTERS**

Hunter (1990:23) points out that among English women:

Like any taboo subject the menopause is rarely discussed seriously or directly. Instead vague terms are used like 'the change', 'mid-life crisis' or 'change of life'. When menopause is openly referred to the most common reaction is embarrassment or laughter.

In North America, Sheehy (1993:26) found that mothers of mid-life women were reluctant to discuss menopause with their daughters and would frequently claim an inability to remember or even deny knowledge of menopause and its associated symptoms. Sheehy (1993:29) points out that the mothers of current mid-life women were of a prudish generation:

...[educated] before the sexual revolution, before liberation, when only 'bad' girls became sexually active before marriage, and a lot of others lied about it...part of the Silent Generation, they have never been comfortable talking about sexual matters. Their silence on the subject of menopause may be an anachronism.

Such views correspond with those expressed by a number of women in the current study. In general, women born before and during the decade following the Second World War remarked on the refusal of their mothers and women of an older generation to discuss any aspect of female reproductive functioning. Many of these women admitted that they lacked prior knowledge of menstruation at the time of their first period.<sup>2</sup> In fact, one third of the women interviewed indicated that their mother had

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<sup>2</sup> Smith (1991:91), drawing on a study of two thousand New Zealand women conducted between 1985 and 1988, noted that 'in the past women were even more silent about the 'facts of life', even to the extent that mothers felt they could not tell their daughters about menstruation'.

never mentioned menopause and that to actually broach the subject with her was unthinkable. Typical of the women's comments were those of Marion\* (aged 65), Jackie\* (aged 61) and Bobbie\* (aged 48):

... [menopause] wasn't a thing my mother talked about a lot, though I don't believe she had a problem with it. She was so reserved about things like that. So you see she didn't talk about menopause, [the] 'change of life', and I doubt if she would have [talked] to her mother [about such things]. That was the way she had been brought up.

I have never, ever talked to my mother about any of those kinds of things, including sex or anything to do with the female body. I have never talked to my mother at all about my own [menopause]...never said a word!

I was a late baby. My mother was forty when I was born, so I was probably about ten [years old] when she reached menopause. She never talked about things like that...you couldn't discuss things like that with my mother and she denied that she ever went through menopause.

Despite the refusal of their mothers to discuss such matters, it was not uncommon for the women to hold childhood memories of oblique references to menopause in the form of gossip which associated unusual behaviour with 'the change'. Jackie\* (aged 61), for example, clearly remembered the expectation that mid-life women 'go all funny...and do all kinds of strange things', as did Sally\* (aged 42) and Marion\* (aged 65) despite the differences in their ages.<sup>3</sup>

Oh yes I was aware of middle-age women going funny and... [other women]... talk[ing] about 'the change'. Probably [it was] just unusual moody action...and... [people] would say, 'Oh you know about her, she is obviously going through 'the change', that's why she is like that'. They wouldn't say it in front of her... but whisper so she wouldn't hear.

I can remember... a school teacher when I was in Standard Three. [That] was probably the first time I heard it mentioned. She would lose it altogether... just turn to the fireplace and put her hands up and burst into tears. We used to be horrified, go home and tell Mum [who said], 'Oh it is just the change of life'.

Moreover, a number of the women remembered references to local, mid-aged women going into an 'asylum' or to 'Porirua' or as Ruth's mother so eloquently expressed it

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<sup>3</sup> Formanek (1990:12-14) casts some light on common sense links between menopause and mental instability. She points out that underlying nineteenth century medical practices of blood letting, use of powerful emetics and cathartics was a notion of the body as a 'closed energy system in which all organs competed for the limited amount of blood available... Women... needed to be sure that their wombs retained an adequate blood supply; their brain's needs for fluids was secondary.' As a result, menstruation, as the elimination of surplus blood, was recognised as an important indicator of a woman's state of health. Once a woman entered menopause, however, it was feared that the lack of menstrual flow may allow blood... [to] enter the brain and cause insanity.'

'Down the mental for a rest'.<sup>4</sup> Similar remarks were clearly remembered by Jill\* (aged 31) whose mother and friends:

...talk[ed] about women who had gone quite mad with [menopause] and had ended up having nervous breakdowns and in Lake Alice. [Menopause] was a thing of dread and terror...that women went quite silly with.<sup>5</sup>

The most tragic account was related by Janice\* (aged 48) who recalled the suicide of a friend's mother (a woman in her mid forties) being attributed to menopause.<sup>6</sup>

Many women also had very clear memories of their mothers and close female relatives exhibiting symptoms which, in hindsight, they recognised as menopause related. Most common was the hot flush, although mood swings and depression, palpitations, headaches and flooding were also noted. Trisha\* (aged 46), Gail\* (aged 50) and Helen\* (aged 62), for example, reflected:

I know my mother went through [menopause] in her late 40s...I can remember her hot flushes and standing there and going all red, sweating...

I remember my mother at Christmas time having to leave the room and go and have a shower and change of clothes and we never really knew why...

[I remember] seeing my mother when she...had [hot flushes]...she would get something out and fan herself...

For Marion\* (aged 65) it was the activities of an aunt which created a long lasting impression:

...I [can] see her, just see her [as I did] when a child. She suddenly went beetroot red and started flapping her arms around and I thought, 'She is going to blow up. She is going to explode', and she would say, 'Oh, it's menopause, change of life', and I didn't have any idea of what she was talking about.

Several of the women recounted episodes of flooding which for some was remembered as a source of embarrassment. Louise\* (aged 38), for example, remembered how uncomfortable she felt as a sixteen or seventeen year old when she found her mother 'Flooding everywhere [she] would make this mess on the floor...when I brought

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<sup>4</sup> Porirua is a mental institution near Wellington. The terms 'asylum' and 'mental' as used by the women in this study refer to psychiatric institutions.

<sup>5</sup> Lake Alice was a mental institution situated near Palmerston North.

<sup>6</sup> Brookes (1992:136) reports that 'female problems' such as the climacteric (menopause), insanity of lactation and uterine disorders made up 13.2 per cent of alleged causes of female insanity in New Zealand asylums from 1898 to 1902.

friends home'. Emily\* (aged 41) and Anna\* (aged 38), on the other hand, referred to their mothers spending prolonged periods in bed:

I think I was quite young, nine or ten, when she was probably going through [menopause] and the only thing I can remember is that she went to bed! I would say it was a period of eight or ten years, it was quite a long time. [People] use to go and visit her. She used to lie in bed and read the bible...so I presume she was depressed. I presume menopause was the trouble, but I am the youngest of six, so I was pretty young. She did seem to be in bed a lot of the time or 'Leave Mum, she's tired' sort of syndrome.

Pamela (aged 50) admitted that she now recognised her mother's frequent screaming and crying, and her strict hard attitude towards her during her teenage years as symptomatic of menopause:

When I look back now I guess she really suffered, but as a teenager I was ignorant of the fact [of menopause] as well as the facts of life, which I was never told.

Beverley\* (aged 39), on the other hand, knew her mother went through menopause at forty-three years of age:

...because my sister was pregnant...and Mum thought she was pregnant too...and she was thrilled to bits! And Dad, not Mum, told me it wasn't pregnancy, it was her menopause.

Episodes of palpitations were among the more dramatic recollections of maternal symptoms. Janice\* (aged 48) and Marion\* (aged 65), for example, both referred to such occurrences. Marion\* explained that:

We all used to expect [my mother] to have a heart attack...it always seemed to affect her in the middle of the night and on more than one occasion I can clearly remember Dad got in a real panic and got the doctor....She really took fright.

Although a small group of the women reported mothers who were prepared to discuss menopause, most described such conversations as inhibited, brief and superficial in nature. Typical of such encounters was that recalled by Monique (aged 48):

I have discussed menopause briefly with my mother but she wasn't terribly forthcoming as women in this age bracket (seventy plus) don't discuss private things like the menopause.

Others, such as Rosie (aged 46), commented that a trouble-free menopause appeared to leave their mothers with little to comment on:

I have discussed menopause with my mother, but with difficulty (and she is still young and educated), but to her [menopause] is not a problem.

Some mothers had, however, remarked to their daughters on their experience of symptoms, which for Barbara\* (aged 57) came with some unique advice:

Mum told me about the hot flushes [and] that her mother had said they were like gold! 'Don't try and stop them or take anything for them, just let them flow and they are really worth [gold].'

Typically though, a mother's mention of symptoms was associated with negativity. Helen\* (aged 62), for example, recounted her mother's inclination towards 'dire predictions' associated with a view of menopause as 'such a terrible time'.

Almost a third of the women felt they could have talked with their mothers about menopause but for a variety of reasons had never done so. A number of the mothers of the women in this group, for example, had died while their daughters were relatively young and felt little interest in the subject. As Trisha\* (aged 46) explained:

I could have [talked with my mother]. She died five years ago and I wish now I had talked to her, but five years ago I didn't even think about [menopause]. I guess I was just only getting into my forties and [menopause] was a life time away! I wished I had because Mum and I could talk about anything like that [but] I couldn't have cared less about it [at that time]...you know I didn't really want to think about it.

Other women pointed to missed opportunities because their mothers were now too old, in frail health or suffering from impaired memory. Communication difficulties associated with distance were also a factor, with women being reluctant to discuss such matters by telephone and feeling a lack of appropriate opportunity when in direct contact with their mothers. Finally, a small group felt there was little point in discussing menopause because of differences between their own and their mother's circumstances. Annette\* (aged 58) explained that:

[I have]...not discussed [menopause] with my mother because she had had a hysterectomy, probably in her early forties...[and so]...went through a different experience. It wasn't something I was sharing...

The women's comments indicate that mother/daughter communication on menopause was typically dominated by inhibition and/or a reluctance to raise the subject. Over one third of the women mentioned that their mothers had never discussed menopause or any aspect of female sexuality. Others felt unable to raise such matters or required the 'right' opportunity to do so. These comments suggest the presence of a social taboo, a conclusion supported by childhood memories of a whispered obscure association of non-conformist behaviour with 'the change'.

Although the women commonly attributed their mother's reluctance or refusal to discuss menopause to a reserve surrounding all aspects of female sexuality, other factors may also have accounted for such reticence. It was clear, for example, that many of the women's mothers knew little about the physiology of menopause or other aspects of their reproductive functioning. Beth\* (aged 71) recalled her mother's reaction when, as a secondary school pupil, Beth told her what she had learned in a human biology class:

...[my mother] had never talked to me about anything and she said, 'Well I have had three children and you know more about how babies develop...than I ever did'.

Beth's mother would, of course, have had a common sense understanding of pregnancy and the development of babies and she could probably explain how she felt and how her body changed while carrying the baby. The point is, however, that if women possess little or no medical knowledge of their bodily functioning (i.e. objective and legitimate knowledge that can be articulated publicly) and because of social constraints feel unable to share their experiences, their experience and common sense knowledge is more likely to remain private and in a sense 'in the mind'. That being the case, a mother's claim of not having gone through 'the change' or an inability to remember experiencing symptoms is quite feasible.

A number of the older women also commented that in the past general practitioners would commonly prescribe tranquillisers for mid-life women seeking help with symptoms. For example, Betty\* (aged 69) recollected:

I knew nothing about [menopause] and as I felt I was approaching an age when it should be happening I asked my old family doctor and he said, 'Don't worry about it. It's all in the mind. Old Wives Tales! You will sail through it'.

On subsequent consultations, when Betty\* did request help for symptoms, she was lectured about her 'fortunate' circumstances ('a lovely husband, two beautiful kids and no financial worries') and prescribed either Librium or Valium.<sup>7</sup> The comments of Betty's doctor indicate his dismissal of the validity of women's experiential knowledge and a linking of symptoms with personal weakness and indulgence - attributes which women may have felt ashamed of and would therefore be reluctant to talk about. This situation would be radically altered with the advent and promotion of the deficiency

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<sup>7</sup> Prescription drugs commonly used as tranquillisers.

disease model. It legitimated the experience of menopause-related symptoms and so facilitated discussion, the sharing of experiences and the treatment of symptoms.

Finally, it is possible that the majority of older women encountered only minimal difficulties or symptoms associated with menopause and so this life-stage passed by largely unnoticed.<sup>8</sup> 'Younger' women, on the other hand, have been exposed to the increased profile of menopause over the last two or three decades, an increase associated with the development and marketing of synthetic hormones. The point is that medical redefinition of menopause as a deficiency disease occurred within a context of taboo and stigma which discouraged the sharing of experiences and promoted the view of symptoms as a product of the mind. Not only did the deficiency disease model legitimate the experience of symptoms but it offered women the prospect of liberation from the stigma of being labelled neurotic, mad and so on. One consequence was the stimulation of a desire for knowledge on the subject. In other words, caught between differing realities, mothers and daughters may find (or have found) themselves separated by two opposing conceptions of menopause; the first being one of menopause as a normal life event of little or no significance and unworthy of comment where, if problems were experienced they were either kept private and stoically endured or if shared were treated with antidepressants; and the second conception is one of menopause as a major (physiological) life transition which requires informed negotiation.

### **WOMAN-TO-WOMAN**

The reticence and inhibition characteristic of mother/daughter discussion of menopause was also evident within the wider community. Many participants in the study, particularly the older ones, indicated a reluctance to raise the subject with others and felt it was not freely discussed among women. Betty\* (aged 69), Marion\* (aged 64)

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<sup>8</sup> A prospective study among two thousand five hundred women in the United States failed to establish a link between menopause and poor health in the majority of women. The researchers point out that stereotypical images of menopausal woman suffering from a broad range of symptoms results from much of the current knowledge being derived from 'a small proportion of self-selecting, predominantly ill women' (McKinlay et al., 1987:110).

and Joan\* (aged 73), respectively, recalled that:

I was always one to have one friend in particular but we never really talked about things like that. Possibly wanted to, but couldn't talk about menopause.

It wasn't the done thing. It was something that was mentioned quietly. Just whispered. 'She's having a mid-life crisis'. Yes! That was a term that was used a bit, 'mid-life crisis'.

Most didn't talk about it. No, people didn't talk about it. It was a sort of taboo subject, sex and that, you know....

Despite being members of 'the silent generation' (Sheehy, 1993:29), however, most older women approved of the more open attitude they observed among younger women. Betty\*, for example, observed that 'the younger ones [are more outgoing] than [women of] my age', and Marion\* admitted she could talk more freely 'with the young ones'. According to Joy\* (aged 66) menopause was never discussed among her older friends but women ten to fifteen years younger than herself were quite open about the subject:

In the groups I am in [women] are much more open. I belong to a [local group] a lot of them are an older generation and I don't think they want to hear about [menopause]. [But] the group I belong to in Palmerston North are quite different. They [are much younger and] will talk openly about sex or [menopause] or anything. It was quite an eye opener! I have got used to it now. [I] enjoy it because they are so open.

Indeed, a number of the younger women indicated a confidence in their ability to openly discuss any aspect of female sexuality. Sally\* (aged 42) put it this way:

I think our generation is far more open in discussing things, we talk about everything. I don't think we have quite reached that stage in our lives yet to have discussion about [menopause] but I don't think it won't be discussed.

A reluctance to discuss menopause was not confined to older women alone. Some of those in their forties and fifties also complained that the subject was rarely talked about.<sup>9</sup> Sue P (aged 44) and Margaret (aged 50), for example, said:

Menopause seems, unfortunately, to be a taboo subject with women as well as men. The few women I know who are going through it whisper quietly together. A number of my friends who have yet to attain this stage don't really want to know.

Women rarely talk about menopause. Maybe that has just been an age group thing and I shall discover something different now that I'm in that stage. Most women believe

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<sup>9</sup> Duncan (1995:84) found New Zealand women identified a 'secrecy surrounding menopause' which they described as, 'A means of preventing women from being able to talk about what was happening to them'.

[menopause] to be a long way off and don't realise that it can happen from forty onwards.

Pamela (aged 50) attributed this reluctance to raise the subject to embarrassment, while Sally (aged 51) expressed her frustration through a proactive approach:

I don't feel that many women talk about menopause. I have made a point of mentioning it to my friends, particularly those who have not gone through it, in order that they may be prepared for whatever symptoms they should experience.

While many of the women signalled some degree of reluctance to raise or discuss menopause in a public situation or even among close friends, others did not feel so inhibited. Colleen\* (aged 54), who had never been able to bring up the subject with her mother, remarked that she found it easy to talk with her friends about menopause. Janice\* (aged 48) and Kath\* (aged 54) had similar experiences:

I have talked to quite a few people...about my age. They will say how they are feeling and I will mention menopause to them because I know it sounds like that is what they are going through, and we often have a chat about that.

I have spoken to lots of friends and acquaintances about [menopause]. It really does you good to discuss the subject - others have similar things happening to their bodies too, some a lot worse which makes me feel better!

It was also clear that the subject of menopause came up in workplace conversation, particularly in female dominated environments, or when events such as hot flushes were observed by others. This workplace discussion was characteristically superficial and had a humorous emphasis. Christine (aged 44), for example, had recently been presented by her seven co-workers (women aged in their late thirties to early fifties) with a birthday card saying, 'When you are hot, you are hot', in reference to her hot flushes. Among the four women Bobbie\* (aged 48) worked with, menopause was not discussed 'seriously' despite constant light hearted reference to the subject:

We had one man at the office. He used to say, 'Even I suffer from hot flushes!', because we used to put everything down to, 'Oh its menopause' [because] we [were] all going through it.

Although many of the participants in the present study indicated a reluctance to raise or discuss menopause in public and private situations this inhibition was not apparent in the research situation. Indeed, any uncertainties I held regarding participant shyness proved to be quite misplaced. Each focus group discussion was lively, frank, enthusiastic and at times intensely personal. They needed little prompting and were

sensitive, tolerant and supportive of each other's opinions and experiences.<sup>10</sup> It was my observation, later confirmed by the women, that they welcomed the opportunity to discuss the subject and enjoyed doing so. An unforeseen outcome of the focus group meetings, however, was the stimulation of interest and discussion among local women and I found myself greeted in public on a number of occasions as 'the menopause lady' and asked about the research. Subsequent comments from a number of respondents revealed a long held desire to talk about such matters, as Ainslie\* (aged 47) indicates:

Well I go to church and I meet one lady and she says, 'Hasn't it been wonderful talking about it'. She wasn't in the group I was at, she was at another one. She told me she was going to be seeing you [again] this week, so she was really excited. I think she is like me, she hasn't got a mother to talk about it [to] and she wants to be able to help someone. I don't know [why but] for some reason women won't talk about it.

Similar sentiments were also expressed by *New Zealand Woman's Day* respondents, with many expressing appreciation for an opportunity to share their views and/or experiences.

The reluctance on the part of mothers to discuss menopause with their daughters and comments indicating reserve, disinterest, whispered conversations and euphemisms all point to the presence of a taboo among older generations of women. Moreover, among older women at least, a degree of mystification was evident in whispered remarks linking the 'the change' with the 'strange' behaviour of some mid-life women. Although the ability of mid-aged and younger women to discuss menopause varied widely (ranging from inhibited through to direct and open conversation with others) the influence of the taboo remains as the references to light hearted jokes and Ainslie's\* comments testify. As a result the sharing of experiential knowledge of menopause continues to be restricted. Given the difficulties of knowledge transmission, it is hardly surprising that women are fearful or hold negative or misinformed attitudes and views; and seek alternative avenues of information which make it more likely that problems will be perceived as requiring individual solutions through negotiation with a member of the medical profession.

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<sup>10</sup> As indicated earlier, these women were a self-selected group who were willing and/or wanted to discuss menopause. However, even taking this into consideration, the anticipated awkward silences and occasional shyness or embarrassment simply never occurred.

## KNOWLEDGE SOURCES

Only a minority among the participants identified other women as important sources of knowledge on the subject. Of these, three referred to the shared experiences of older friends, while the remainder had talked with others of approximately their own age. For the majority of the women, however, the prime source of information was written material. While some had combed the shelves of the local library in search of information, others had purchased books or been lent them by a friend or their general practitioner. In most cases the books referred to were manuals produced by overseas authors. Very few of the women were aware of the New Zealand manual by Raewyn MacKenzie (1984) while no-one mentioned the more recent publication by Leteia Potter (1991).

Many were critical of the availability and quality of this printed information which they complained did not address their particular questions. Some, such as Pamela (aged 50) and Monique (aged 48), felt frustrated by the academic nature or repetitiveness of available books:

I am in the process of menopause, which is an oblique word in my opinion. No-one seems to be able to tell me exactly what it is. I know [menopause] is the ceasing of your periods, but when exactly are you menopausal and when exactly do you become normal again? I cannot find this information, books have been written...most of them waffle on and repeat themselves.

There weren't many books, perhaps two, in the library that I remember six years ago. One of them was far too academic and involved for me to enjoy. The second was easier to follow.

The notion of menopause as an 'abnormal' state referred to by Monique reflects the common sense association of 'the change' with a finite period of vulnerability to 'abnormal' somatic experiences such as hot flushes and behavioural changes involving 'going funny' or 'losing it'. In common with most of the women in the study (see her narrative in Chapter 7), Monique clearly expected that the symptoms she experienced over recent years and attributed to menopause were a temporary aberration. Her dissatisfaction with the literature on menopause, therefore, is that not only does it fail to address or confirm her preconceived view but it presents the very same knowledge ambiguities identified by the general practitioners.

Not all of the women, however, felt dissatisfied with the printed material on menopause. Jill\* (aged 31), along with several others, pointed to the *Readers Digest* medical journals as an invaluable source of information on general health issues, including menopause. Mary Ann\* (aged 49), on the other hand, commented:

I have hit most of the books I could find. I like that little New Zealand one [Raewyn MacKenzie] because it is at least New Zealand and I have got lots of women's health books and they all have a chapter on [menopause]. The other thing I get is an American health magazine from the States and occasionally they will have something and I like them because they are actually research based.

Magazines were also a popular source of knowledge, particularly if articles provided details of women's experiences. Colleen\* (aged 54), for example, commented:

I have read about [menopause] over the years. I used to get a lot of women's magazines and just read about everything in them. That's where I got the bulk of my information.

Noeline\* (aged 61) thought magazines provided an important forum for medical people to write about topics such as menopause but pointed out that she did not buy certain types of magazines:

...because I find them pathetic. I want to read something that is going to be a little more knowledgeable [although] every now and then you find these little gems in [such] magazines.

Noeline's\* comments signalled a curious ambivalence which was displayed also by some of the other women. On the one hand, magazines were acknowledged as an important source of information, while on the other the reliability of information presented was queried as Ainslie's\* comments indicate:

...the only stuff I really found was in the women's magazines and it was not very accurate...its very emotive, flimsy...they are not really interested in in-depth [investigation]...I mean *Women's Weekly*, *Woman's Day*, they are just junk and they dish out these little bits of rubbish.

Noeline\* and Ainslie's\* comments also signal a distinction between the quality of magazines. Many of the women thought the widely circulated weekly magazines presented less reliable information than the glossy, more up-market, monthly publications.

Although the comments of Noeline\* and Ainslie\* identify a level of dissatisfaction with some of the material published by the popular magazines, these publications nevertheless constitute an important source of knowledge given the ongoing impact of the taboo surrounding the social discussion of menopause. The popular magazines

provide a forum where the socially unmentionable or awkward can be addressed. In this way they offer anonymous access to personal accounts of menopause experience and so present the opportunity for women to vicariously share the experience of others. The drawback with this type of information (as the comments of Ainslie\* and Noeline\* suggest) is its tendency to focus on the unusual, extreme and sensational. In this way popular magazines may confirm common sense perceptions of menopause as a 'bogey' or negative event and, perhaps more significantly, provide experiential accounts which do not resemble the experience or perceptions of many of their readers. In other words, their material may fall short of providing the 'balanced' information the women indicated that they desired in Chapter 4 and so stimulate the desire for further knowledge.

Consultation with either a medical practitioner or practice nurse was another popular source of information. Frequently the outcome was the provision of pamphlets or a book to read but not everyone was satisfied. In Ainslie's\* case, her doctor sought information from Auckland University:

...he said Auckland University put out wonderful literature and they will send it to my house. He said he didn't keep stuff in the surgery, he just sent people's names away...but they were just two little folders that opened out, three pages. Both were to do with HRT.

Helen (aged 50) - 'hungry' for information - found the pamphlets and answers to questions provided by her doctor 'all rather limiting'. On the other hand, Joyce\* (aged 57) found her doctor 'excellent' as he informed her of what to expect at a time when she knew very little. Catherine\* (aged 48) received *Understanding Menopause* (3M Pharmaceuticals) from her doctor. It was the first time she had been given anything to read about menopause. A few, like Pauline\* (aged 35), found contact with the practice nurse the most satisfactory means of obtaining the required information.

Three of the women (at home with young children) mentioned seeing an Oprah Winfrey show when Gail Sheehy, author of *The Silent Passage*, appeared as a special guest. All three commented they knew little about menopause prior to viewing the programme and rated the interview as 'quite good'. For Trisha\* (aged 31) the programme was memorable for its promotion of Sheehy's book which she eventually managed to get hold of and read:

...it took about a year before I could get it. I didn't agree with a lot of it. I thought it was very American... [although] it was basically a good book.

Lorna\* (aged 42) also took note of Sheehy's book as something of possible interest in the future, although her lasting impression of the programme concerned:

...[the number] of younger women who had had hysterectomies early for whatever reason and [how] they had started getting all these symptoms and I thought, 'Oh my goodness!'

The show's emphasis on menopause-related symptoms challenged Lorna's\* perception of menopause as a time of a 'surge of energy and vitality [when women ] really start doing new things'. Lorna\* and Noeline\* also mentioned National Radio as an information source, although neither could specifically identify the programmes heard.

A small number of participants had attended women's health education programmes, including Family Planning Association workshops, in their area. Pamela (aged 50), a resident in a provincial city, attended a seminar put on by a local health nurse and came away 'amazed at the women there (about twenty of us) who knew nothing'. Although the nurse explained the physiology of menopause quite well, the programme failed to meet her expectations. 'I thought I'd learn something but I seemed to know it all, more than the others [attending the seminar], so it was a waste of time!' Annette\* (aged 58) attributed some of her knowledge to a Women's Health Day held in Feilding about ten years earlier.<sup>11</sup> She remembered a talk on menopause by a woman doctor as very helpful and practical. Paula (aged 43), on the other hand, received material from the Brisbane Woman's Health Centre and *Women's Health Watch* in Auckland:

...someone told me about [the Brisbane Centre], so I wrote to them and they gave me a good bundle of information. I read in a magazine about Sandra Coney's *Women's Health Watch*, so I subscribe to their newsletter now.

Perhaps the most interesting health education knowledge source, however, was that described by Marion\* (aged 65):

I probably had quite a good knowledge of [menopause] because as a girl [in the 1940s] I went to Feilding Agricultural High School. We had a very innovative, go-ahead, head master [who]...encouraged the girls [to attend what] I suppose was a branch of human biology, but was called Child Psychology. That was a very broad term for the subjects covered and one was [on] the human body and its workings from birth to death, and [menopause] was covered in that.

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<sup>11</sup> The Women's Health Day referred to by Annette\* was the only programme available to Feilding women in recent years. Even in nearby Palmerston North, menopause workshops run by the New Zealand Family Planning Association had been in recess for approximately five years at the time of interviewing.

Finally, those women who worked in the health area pointed to the acquisition of knowledge through their employment. Moira, for example, pointed out that as a clinic nurse she didn't need to seek information 'as it [often] just came up' on the days she worked in the hospital gynaecological clinic. Similarly, as a practice manager for a medical centre, Merle (aged 52) found she had ready access to information and resources and in fact provided me with details on how to access the Novo Nordisk video *A Change for the Better: Menopause and HRT Explained*. Merle was one of only two *New Zealand Woman's Day* respondents who spontaneously indicated that they had viewed either of the videos discussed in the previous chapter.

### **Commentary**

Overall, printed material was the most common and preferred source of information on menopause. The women usually sought out books and magazines themselves, while pamphlets were typically provided or obtained through health professionals such as general practitioners, practice nurses or occasionally from pharmacists. It was common knowledge among the Feilding-Manawatu district women, for example, that a local pharmacy carried a comprehensive range of health-related pamphlets. That fact that the women indicated a preference for written material appears to be a reflection of the continuing impact of the taboo surrounding social discussion on the subject. Printed material provides a range of publicly available views and knowledge from sources as diverse as pharmaceutical companies to women's health groups which can be consumed in private without fear of embarrassment, censure or stigma.

Surprisingly few of the women had attended menopause education programmes. For the Feilding-Manawatu district participants this could be explained by a lack of opportunity, but that may not necessarily have been the case among the *New Zealand Woman's Day* respondents. Alternative explanations include a possible lack of awareness of programmes or hesitation/shyness about attending such an event. Indeed, several women hinted at a stigma associated with menopause as an indication of ageing. Rosie, for example, expressed a reluctance to attend a menopause support group for fear of 'being labelled', while Ainslie\* was bemused by the reaction of several acquaintances who said - in response to her involvement in a focus group - that they had not realised she was 'that old!' Nor can the impact of a youth orientated

culture on the decisions and experiences of mid-aged women be discounted. Lock (1993:377), for example, points out that in North America the worship of youth creates a perception of ageing as abnormal, and as a result 'the menopausal woman stands for what has been... someone who stands on the wrong side of average'. Such a perception may well underlie the comments of Rosie and Ainslie\*, and will be examined further in the following chapters. Finally, a lack of attendance at educational workshops could be a further indication of the impact of the taboo. Many women may have felt uncomfortable about attending an event such as a workshop that involved, in the company of strangers, participation on a subject considered personal and private, a subject they were reluctant to talk about with friends and workmates. The success of the focus groups, however, appears to challenge such a conclusion by demonstrating, in fact, just the opposite. In other words, it appears that women will respond if given an appropriate forum to discuss and share their views and experiences of menopause. The difficulty here, however, is that it is also possible that in the focus group situation the women were merely responding to a 'researcher' as a 'safe', neutral stranger, empathetic to their views and experiences. If the latter is the case, it suggests that social discussion of menopause remains surrounded by inhibition and a fear of being labelled.

A further point concerns criticisms relating to the nature, availability and quality of information. Some of the comments signal an ambivalence between a desire for: subjective, experience-generated knowledge, as represented by many of the women's magazines; and medically authenticated 'facts', commonly found in books and pamphlets. Indeed, juxtaposition of the life-stage and deficiency disease orientations appears to account for perceptions of experience-generated knowledge in women's magazines as 'junk' or 'rubbish' and the medical knowledge as too academic, repetitive or failing to address personal concerns. Pamela's assessment of the health seminar she attended illustrates the point. She considered that the nurse explained the physiology of menopause 'quite well', but complained that she hadn't learned anything and it 'was a waste of time'. Reiteration of the physiology of menopause had failed to provide a practical solution for someone struggling to cope with unpleasant symptoms. Hence her dissatisfaction with the seminar content and the nurse's lack of attention to individual subjective experience. The irony, of course, is that in the event of emphasis

being placed on subjective experience, an assessment of 'a waste of time' is still highly likely given comments such those made by Ainslie\* on the quality of information presented in magazines. In essence, the women are caught between two constructions of reality; between a view of menopause as an objective, pathological and biologically uniform event and a view of it as an individually experienced, socially meaningful, life passage. The chasm between these views is enhanced by the privilege accorded to biomedical 'facts' and the paucity of high quality, experience-generated, common sense knowledge. Neither perspective is able to satisfactorily fulfil the expectations of women and so a situation of ambivalence develops.

### **THE WOMEN'S KNOWLEDGE**

In view of the privilege accorded to medically orientated facts, the discussion turns now to the extent of the women's knowledge on the physiology of menopause and their assessment of the adequacy of their personal knowledge. When asked to describe the exact nature of physiological changes at menopause, most women (aside from those with a nursing background) offered vague responses which emphasised the end of menstruation, cessation of ovarian functioning, hormonal change and symptoms. For example, Jacky\* (aged 55) and Pat (aged 54) emphasised the role of hormones:

All I know is that your hormones change and you are not needing the same hormones as you did.

I don't know much about the actual process except that certain hormones are no longer being produced therefore causing the cessation of menstruation. I don't know what causes these hormones to no longer be produced.

Monique (aged 48) and Pamela (aged 50) linked hormonal change with ovarian activity:

I know the ovaries are stopping their production of eggs but that our oestrogen supply doesn't disappear altogether. The hot flushes, from what I can gather, are probably something to do with fluctuations in the body's heat regulatory systems. Hormones going haywire for a while as they do in adolescence.

All I know about the physical process of menopause is that the ovaries gradually stop making eggs and oestrogen...the ovaries shrivel up and...the lack of oestrogen in the body causes these symptoms.

As indicated by their comments, the women placed considerable emphasis on the role of hormones in all aspects of their reproductive functioning and experience of sexuality. Hormones were commonly attributed responsibility for a wide sweep of life-

time experience, commencing with the onset of menstruation and including the occurrence of pre-menstrual syndrome, menopausal symptoms and the process of ageing. However, despite their widespread use and common understanding of the term 'hormone', very few of the women were able to explain exactly what they were referring to or the function and role of hormones in the body.

Given the vague understanding of menopause physiology, it was not surprising that only a handful of women indicated satisfaction with their level of knowledge. Sue P (aged 44), for example, felt 'well clued up' about the physical process of menopause and Annette\* (aged 58) also said that she felt 'well informed'. But the same could not be said for the majority, who assessed their knowledge as either insufficient or incomplete. Trisha\* (aged 46) admitted to being 'absolutely ignorant of the whole thing' prior to the onset of symptoms, while Beverley\* (aged 39) said she only knew about hot flushes. Catherine\* (aged 48) still felt ignorant of what was going on in her body, while Jacky\* (aged 55) pointed to disinterest as the factor underlying her ignorance at the onset of menopause:

I didn't know a great deal about it. I knew that you had changes mostly in how you felt. I just thought your periods stopped...I just didn't think about it a lot. I just knew it was coming.

A characteristic of most (but not all) older women, such as Jackie\* (aged 61) and Judy\* (aged 56), was their complete lack of knowledge at the onset of menopause:

I didn't [know anything about menopause]. I don't think I did. I guess I started to try and find books and...find out about it when I realised something was happening...

I didn't know anything. I knew nothing about my body change...nothing, nothing! It's only the last...oh possibly three to four years that I have actually read a little about it.

Many of those who expressed dissatisfaction with their level of knowledge indicated a desire to know more about the physiology of menopause. Colleen\* (aged 54) noted that despite familiarity with the mechanism and process of the menopausal transition a number of her questions remained unanswered, while Rosie (aged 46) admitted feeling:

...uneducated about my experience of the menopause as a 'baby boomer'. I have always found information on most parts of my life to be accessible but I found information on menopause difficult, especially with answers to my questions.

Zelda (in her mid 50s) complained that although she knew a little about the physical process, she 'never knew what menopause was *exactly*'. Others, such as Marilyn (aged

51), pointed to confusion generated by conflicting views on the appropriate management of menopause:

It's really hard to know at the time what to believe when you get such opposing points of view. All you can do is discuss the issues, talk about the pros and cons and make an informed decision.

Catherine\* (aged 48), on the other hand, said:

I would love to know about my body. Even though you might see pieces of paper [explaining menopause] I still don't understand. I actually need someone to sit and go through it and tell me what everything does. You see I still don't understand, even though I keep reading...what oestrogen is.

Catherine's\* remarks encapsulate much of the dissatisfaction expressed regarding the quality, accessibility and personal levels of knowledge. But what could be done about this. The women offered many forthright suggestions on how to best rectify the situation. Some, such as Sue P (aged 44), wanted:

...more information available about every aspect of menopause [and which makes it clear]...that you don't have to be fifty to begin having menopause. That mid-thirty year olds can begin to have symptoms.

Sue P's comments echoed the frequently voiced confusion and concern over the age of onset of menopause. Other women indicated a desire for better written information, with Jan (aged 56) suggesting the 'compilation of information sheets into a [guide] book' while Monique (aged 48) believed that:

An inexpensive fun book with facts and figures and supportive information is what the average woman would like to read. [A book which would] let [women] know there is nothing wrong with them if their menopause happens to be a bit different from Mary Smith's next door.

A desire for more formal education programmes, preferably run by health professionals through women's organisations, was also indicated. Dulcie (aged 78), who found menopause a very difficult stage in her life, strongly advocated the need for women to be taught about the 'possible effect' of menopause and suggested that 'medical personnel be approached to lecture women...approaching the menopausal stage...and invite questions from the women'. The most common suggestion, however, was that information be made readily available through doctor's surgeries. Sue O (aged 48), like Zelda (mid 50s), wanted 'a small booklet on the symptoms and treatment' of menopause left in doctor's waiting rooms. Others suggested pamphlets be distributed to all older women when they attended for a cervical smear, and a small group felt pamphlets specifically aimed at husbands and partners should be made available. Rosie

(aged 46) wanted to 'see more general practitioners preferably women, advertising their speciality as 'the menopause helper', while Paula (aged 43) suggested that doctors' surgeries and health centres display on their notice boards the names of contacts 'so that [women] know what is available in the way of help and [can] quickly obtain meaningful information through networks or [personal] contacts'.

Paula's suggestion raises the issue of menopause support groups for mid-life women. The majority responded positively to the idea with some, such as Dulcie (aged 78), holding strong views on the value of such groups:

Definitely...very necessary as this is one of the most traumatic periods of a woman's life...perhaps suitable women who have been through this phase could be co-opted and be on hand for any queries.

As someone yet to reach menopause, Lorna\* (aged 42) remarked 'It would be nice to know that there is somewhere you could go to when this is happening to you'. Sue P (aged 44) was of like mind but argued that they be accompanied by: a regular newsletter as a forum where women could say 'I tried this and it worked for me'; as well as a counselling-type telephone line to service women's queries. Others saw support groups themselves as a way of providing women with an opportunity to informally share experiences, views and knowledge. Paula (aged 43), for example, felt that such groups would prevent individuals from loading their problems on friends, and Catherine\* (aged 48) believed that being able to talk and share personal experiences with others would be very reassuring, 'You know, moan and groan because you think when you go into [menopause] you are the only one going through this'. Finally, there were those, such as Megan (aged 49), who saw support groups as an opportunity to educate both men and women on the subject.

In contrast, a small group of women expressed strong opposition to the establishment of support groups. The most adamant were Sylvia (aged 65), Zelda (mid 50s) and Pat (aged 54):

...women should be looking after their own health problems themselves and a support group in this instance is not needed.

Personally I don't think support groups are necessary. People in support groups tend to draw attention to themselves and just want sympathy. Let's all get on with life and accept what is happening to our bodies without all this so-called supportiveness.

I think this sort of thing can be a bit navel gazing and unnecessary...support groups...could well degenerate into mutual moaning sessions.

Rosie (aged 46), although sympathetic to the idea, wrote that she 'would not attend for fear of being labelled'.

Viewed in the context of the remnants of the taboo on discussion about menopause and the ambivalence towards available knowledge sources, the diversity of opinion on the need for support groups is not unexpected. However, implicit in the comments of those favouring support groups was a desire for answers and solutions to difficulties. From this perspective, the establishment of a support group network would allow women access to experience-generated knowledge. Taken to another level, support groups have the potential to foster a common sense knowledge base, to provide a site for the interface of the biological and the socially meaningful, and so have the potential to bridge the two constructions of reality. That said, however, it is acknowledged that support groups may not always be the most appropriate knowledge dissemination method for all women.

## CONCLUSION

Writing in the late 1980s, Ballinger and Walker (1987) pointed out that until very recently menopause has been a taboo topic in Western culture. As clinical psychologists with extensive experience counselling Australian women, they found that (Ballinger and Walker, 1987:1):

Women themselves seem often to avoid the topic. We know from our own clinical experience that women often avoid discussing it with each other, even when they are worried and even when they discuss other personal areas, like marriage problems, quite openly.

Comments by participants in the present study point to a similar situation in New Zealand. The remnants of a taboo are manifest in the lack of mother/daughter discussion and a continuing reluctance among women of all ages to broach the subject with others. I have argued that the result is a paucity of experience-generated, common sense knowledge on menopause and an associated climate of misinformation, negative attitudes and ignorance about the nature and outcome of this life transition. This

situation is graphically illustrated by the earlier association of 'the change' with madness and more recently with depression.<sup>12</sup>

Generally the women associated 'information' (rather than the term 'knowledge' as usually defined) with the 'factual', 'value-free' material obtained from authoritative sources. On the other hand, the term 'knowledge' (rather than 'belief') was employed in reference to the realm of common sense knowledge, comprising stereotypical and often negative views such as those presented through jokes and whispered comments. It appears that the social taboo surrounding menopause has constrained the women's access to knowledge and has compelled them to seek alternative sources of information which can be consumed in private. Hence, the most preferred source of information is written material which allows them anonymous and private access to publicly aired issues, experiential knowledge and medical 'facts'.

The common sense knowledge base and the associated negative stereotypes emphasise that this event is 'all in the mind'. Where public disclosure of what is 'on the mind' can lead to censure the outcome is that popular knowledge of menopause is vulnerable to the process of medicalisation. Medical promotion of menopause as a universally experienced, biological event, independent of individual meaning and social influences provides an apparently value-free, objective acknowledgement of this life-stage transition. The impact of the medical explanation of menopause was evident in the women's equation of 'quality' information with biomedically authenticated 'facts', their questioning of the validity of narratives and commentaries offered by popular weekly magazines, and in their usage of the term 'hormone' to convey perceptions of bodily processes and associated subjective experience. Although very few of the women were able to explain exactly what the term 'hormone' referred to, there nevertheless existed an assumption of shared understanding as to its exact meaning. Such features are indicative of the process of medicalisation which involves, among other things, the incorporation of medical terminology into the vernacular and an associated popular reconstruction of perceptions of bodily functioning (Van Esterik, 1989:114).

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<sup>12</sup>See Liao and Hunter (1995) and Kaufert (1994).

In general the women expressed dissatisfaction with both available knowledge sources and their own level of understanding of the physical process of menopause. With a few exceptions, however, what was surprising was their lack of awareness of currently available information and educational programmes. For example, New Zealand Family Planning Association workshops are regularly held in many centres while an increasing number of workshops/seminars are offered by practice nurses or community health groups throughout the country.<sup>13</sup> In addition, the Auckland based Women's Health Action Trust provides its members nationwide with a range of printed information on specific aspects of menopause as well as a regular newsletter which details and critiques recently published research on the topic.<sup>14</sup> Moreover, very few women participating in the study were aware of the range of pamphlets and booklets available, of Coney's (1993) book, or (despite their requests for locally produced information presented in 'an inexpensive, fun' format) of the two locally written manuals.<sup>15</sup> It should be clear from the above that these points concerning knowledge sources and dissatisfaction with the level of their own knowledge, were common to both the Feilding-Manawatu participants and the *New Zealand Woman's Day* respondents.

What does the above tell us about the characteristics of common sense knowledge on menopause among New Zealand women? It would be fair to conclude that the women's knowledge is eclectic, disjointed, inherently contradictory and reflects the privilege accorded to one source over others. Although varying in content between the older and younger women, it is drawn from a variety of sources that include personal experiences, overheard whispered comments, childhood observations, popular magazines, medically orientated material and educational programmes. It is disjointed in the sense of not forming an integrated whole, encompassing positive and negative stereotypical beliefs as well as scientifically established physiological processes, and is fraught with contradictions reflecting the accommodation of competing constructions

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<sup>13</sup> For example, a seminar titled *On Women's Health in Menopause*, hosted by the Matamata Quota Club, 10 February 1996, involved sessions led by a community health nurse, community dietician, physiotherapist, natural therapist and fertility educator. In Nelson, the Independent Nursing Practice ran a *Menopause Seminar* on the evening of 28 February 1996.

<sup>14</sup> Examples of publications on specific aspects of menopause include, *A Guide to HRT and Help for Hot Flashes*.

<sup>15</sup> See MacKenzie (1984) and Potter (1991).

of reality. The most notable contradictions arise with the juxtaposition of the deficiency disease and life-stage models of menopause, particularly in the context of a youth orientated culture that values female attractiveness and sexuality. Moreover, it has been demonstrated that given the choice between the two models, the women accorded privilege to apparently value-free, medically orientated 'facts' and desired improvement in their level of understanding of the physiology of menopause. That said, they also indicated a need for experience-based, subjective understanding of this life passage; a need which appears to indicate that they did not wholeheartedly 'buy in' to the medical explanation of this event. Indeed, their dissatisfaction with current knowledge sources confirms a tension between the two constructions of reality and a desire for an integrated understanding and explanation of menopausal phenomena. As will be shown in the following chapters, it is this common sense knowledge (with all its strengths and shortcomings) that plays a significant role in shaping and informing the expectations, perceptions, meanings and experience of menopause among New Zealand women.

## Chapter 6

### Perceptions, Attitudes, Expectations and Meanings

God said to Abraham, 'As for your wife... I will bless her and will surely give you a son by her.' Abraham... laughed and said to himself, 'Will Sarah bear a child at the age of ninety?' Then God said, 'Yes....your wife Sarah will bear you a son, and you will call him Isaac.'  
(Genesis, 17 v.17-19)

Commenting on trends in menopause research, Davis (1996:70) argues the need for acknowledgement of the complexity of menopause as a bio-cultural phenomenon, and as the product of a dialectical rather than a linear relationship between biology and culture. Davis's position epitomises a developing dissatisfaction among social researchers towards a view of menopause 'as a syndrome based in the hormonal biology of the female reproductive system' (Davis, 1996:67). Her point is that the medical view of menopause embodies a priori, culture-bound assumptions that simultaneously project and reinforce dominant social values.

A significant contribution of feminist research has been the critical examination of the historical development of biomedical discourse surrounding the knowledge and treatment of female reproductive functioning. Fundamental to the feminist critique is the exposure of a link between biomedical understanding, explanation of female reproductive functioning and social notions of what constitutes the feminine. The feminist critique has focused on the situation of the European middle-class woman, whose situation constitutes a relevant 'beginning' for the examination of meanings of menopause within New Zealand - a society and culture still dominated by its European colonial origins.

The nineteenth century medical focus on the uterus as the regulator of female well-being has been viewed by feminists as a manifestation of the veneration of motherhood and domesticity that emerged at the peak of the European industrial revolution (Quinn, 1991:306; Barbre, 1993:25). Within New Zealand the association of femininity with

motherhood was part and parcel of the colonial scene where the ‘ideal’ woman in addition to the ‘virtue’ of her fertility was a wife, companion, housekeeper and source of additional labour (Kedgley, 1995:21). The association of femininity with motherhood prevailed for the larger part of this century, sustained by developments such as the establishment of the Plunket Society and the introduction of domestic science programmes in schools (Olssen, 1981:4).<sup>1</sup> During the 1930s official concern over the falling birth rate perpetuated this view of femininity as women were encouraged to ‘recapture the glory of motherhood’ by rearing large families (Kedgley, 1995:74).

Matthews (1984:88) points out that the ideology of motherhood ‘held sway...because it had become part of common sense’; that is, marriage and motherhood were the popular social measure of normative definitions of the feminine. Kedgley (1995:115), for example, points to the role of the *New Zealand Woman’s Weekly* in the 1930s in reinforcing such a view via its promotion of ‘motherhood as a woman’s vocation and biological destiny’. As an indicator of just how deeply entrenched this view was in New Zealand society, a vignette titled ‘War Widows of a Kind’ (Anonymous, 1986) poignantly portrays the stigma of spinsterhood. The author draws attention to the impact at the end of the Second World War of casualties among servicemen on young New Zealand women who were (Anonymous, 1986:234):

...among the last of those raised in a society whose main expectations were that they would make good wives and mothers, and which gave the title of ‘respectable’ to a woman because she was married.

For such women, frequent social comments on their failure to meet ‘Mr. Right’ conveyed the common view that ‘it was incomprehensible that anything other than marriage and motherhood could lie ahead for any *normal* young woman’ (Anonymous, 1986:236).<sup>2</sup>

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<sup>1</sup> Established by Truby King, the Royal New Zealand Plunket Society (Inc.) focused on improving the quality of motherhood through the implementation of scientific rearing of infants. King, motivated by a concern for the state of infant and maternal health at the time, believed that the decline of major civilisations was linked with increasing selfishness and a lack of personal discipline. He attributed poor infant health to women’s loss of maternal instincts and the ‘spoiling’ of babies (Olssen, 1981).

<sup>2</sup> My emphasis.

The more recent emergence of a youth orientated culture, and the development and promotion of sex hormone therapy, has complemented common sense understandings of female worth and sexuality. Here the normative definitions of the feminine remain uterine-dependent but the focus has shifted from fecundity to fertility. Consequently, female sexual potential has become increasingly central to the social construct of femininity. Matthews (1984:90) links this development with more permissive sexual attitudes which encourage 'pleasure divorced from the probability of procreation', which promote female sexuality, allure and attractiveness, and which encourage a woman 'to be seductive as well as nurturant'. Indeed, the association of femininity with fertility was fundamental to the clinical perspective of Wilson (the original advocate of oestrogen replacement therapy) who viewed post-menopausal women as 'de-sexed', 'de-feminised' beings on account of their lost fertility and associated risk of oestrogen-related 'diseases' (Coney, 1993:63-63). While many practitioners may have dismissed Wilson as a 'crank', his ideas nevertheless reflected commonly held notions of what it is that constitutes womanhood. Such ideas, as Lock (1995:377) observes, ultimately promote the notion of ageing women as abnormal and deviant in the face of the sexuality and vigour of youth.

How then do the women in the current study see menopause? As a positive event to look forward to? A natural life-stage or an event to be approached with trepidation and dread? What factors influence the formation of their views? These questions are pursued in this chapter which explores the women's perceptions, attitudes and expectations. The discussion begins with the narratives of eight women selected for the range of views presented. Four of the eight (Sue N, Mary Ann\*, Nora\* and Marie\*) had yet to reach menopause while the other four (Jacky\*, Kath\*, Paula and Pat) had passed through this event which, in Paula's case, occurred while she was still in her early thirties. Together, these narratives provide an introduction to three different understandings or meanings of menopause which are discussed in detail in the remainder of this chapter.

## EIGHT NARRATIVES

### Jacky\*: A Reward

Sitting in the sun by a tree alive with native pigeons, on a grassy terrace overlooking green hills with Mt. Ruapehu in the distance, Jacky\*, a fifty-five year old rural housewife and mother of five, shared her views on menopause with me:

I probably look at it differently now. In my thirties and forties I didn't think of it much at all. It's probably only since I was about forty-eight that I started even looking in magazines. I used to flick over that part of magazines, it was for old women and it didn't worry me at all as it seemed not to concern me even though it was going to happen... I didn't look on it as being a problem. I didn't know a great deal about it, I just knew that you had changes mostly in how you felt. I just thought your periods stopped and that was it. There weren't a whole lot of other physical discomforts or anything like that. I just knew it was going to come and that I was going to be able to cope with this because I had an idea that sometimes these things were a mental attitude and I felt 'I am a positive person and it is not going to worry me at all'.

I know of some men who have an attitude that says 'Oh she has got a mental problem'. I have heard that one and I think there are a lot of New Zealand men [who] could have that attitude. I am talking about the chauvinistic type of men and I think it has an important part to play in how a woman reacts. If [a woman] is married to a man like that... she wouldn't want to do anything or say anything that could suggest that she is going through menopause because he will be thinking 'Oh she has got a mental problem'.

The only thing that I probably thought was [a bit scary about menopause] was that you probably became an old woman. Like you get to the gate of menopause and you go through it and you are an old woman. You know, you probably lose that attractiveness or whatever you call it [but] I think [this idea] is a myth. I think that anything that you lose... through going through menopause is only because you have lost it yourself! Its not menopause that has made you lose it. The only thing I have gained is grey hair... it would have been nice to keep my own hair colour during this time. To me that's probably the only visible sign that I have gone through menopause, even though it doesn't mean that I have gone through menopause.

Well now when I think about menopause, I think it is a great thing for women my age. You have not got the discomfort of periods, that's a great freedom really and you haven't got the fact that you could get pregnant. So I think sex can become a great thing without that fear of becoming pregnant, because at my age now I don't think I would [want another child]. There are other goals that I want... now that my childbearing years [are over]... other things now that I can put my life to and I think now I would enjoy seeing grandchildren.

What else has changed me in my thinking... I suppose... is the freedom as a married woman... it is almost like a reward for bringing up your children. I look on it as a reward. You have been through the childbearing and the child rearing and its not easy especially with teenagers, and its like you have got through that stage and now here is your reward. You have got freedom. Your body's free of menstruating and you have got sexual freedom too

and you have that time where you can develop things. You know the husband and wife can devote things to themselves and I look on it as being a reward time.

### **Pat: Sadness and Ageing**

A *New Zealand Woman's Day (NZWD)* respondent, bookshop owner and resident of a lower North Island coastal settlement, fifty-five year old Pat wrote:

How do I feel about my experience of menopause? Sad at the passing of the years and trying to remind myself that growing older is a privilege. I've known a lot of people who haven't reached the age I am now and I suppose we must accept the natural process of ageing. I can remember I hated developing breasts and hair under my arm pits too! A reluctance to get older.

I [did] seek information on menopause. Mostly from books [but] also from my GP regarding his opinion on HRT. I was first sent to a specialist... who gave me various tests - sent me for a bone scan and breast examination. I come from a heart disease prone family and was concerned that I'd lose my 'natural protection' when I reached menopause and was thus attracted to HRT if it could restore oestrogen levels and help protect against heart disease.

For so many years the talk [among women] was about periods and pre-menstrual tension, what sort of sanitary protection was best and how the men in our life reacted to our moods, and so on. Now, almost before we're aware, it has ended; that monthly lunar rhythm is no more. Instead, half amused and half sad, we find ourselves discussing with resignation the problems of ageing. When we were young and had a cold or the flu we knew it would go away. Now so much of what is happening to us is here to stay.

I had my first period at the age of eleven. I do remember having to wear bulky pads made from old babies' napkins and washing them afterwards, soaking them in cold water and then washing in hot. What a pain! I remember having some awful cramps when I first started having periods. The men in my life believed I had pre-menstrual tension and I probably did, though naturally I always thought my bad tempers and moods were caused by objective and valid situations. But the 'upside' of having periods was the great feeling of physical lightness and well-being I had when my period ended each month. It was a regular cycle and that week or so of great well-being after the end of a period was almost worth the irritable discomfort. Menopause brings a certain equilibrium which I suppose goes along with getting older.

With friends and then my daughter, we sometimes would notice and talk about the phenomenon whereby women who live together, or are fairly close, tend to synchronise their periods. My daughter started having periods when I was still having them and it became quite interesting to notice if this was happening with us, 'both women together'. When I entered the menopause this could no longer occur and I found it rather sad.

In many ways I miss having periods - the feeling that I could still conceive a child, the wonderful well-being at the end of a period - but I suppose I don't miss the heavy bleeding and the irritability before they started. Menopause is a challenge in a way - a reminder that we are no longer linked to the rhythms of the moon, no longer biologically necessary. Any extra life we have is a 'bonus' and we must find our own function to give it meaning.

### **Kath\*: Anticipation and Health Concerns**

A fifty-four year old school teacher from the Feilding-Manawatu area, Kath\* told her story during a focus group meeting.

I thought it was something that you could be positive about and so therefore it wouldn't affect me. I do remember hearing that my aunt had gone through menopause by the time she was about thirty-eight and thought that would happen to me. Lots of people have said to me that [they] never knew that it had happened, they [just] stopped menstruating and I thought, 'Oh well, they [have] good positive attitudes... I'll try and adopt one' and it just didn't work for me.

I was going to ignore it and let it pass by but unfortunately it caught up with me. I have thyroid problems and I don't know quite whether [menopause started] before I knew it and it was being blamed on the thyroid... I suddenly realised that 'Hey this was not just thyroid trouble', it [was] probably menopausal. I went to the doctor and worked through it with him and actually I am now on HRT. The thing that was different in my life was that I was waking up about four o'clock in the morning [with] a real anxiety attack [about] what was happening around me and that had never [previously] happened, not even when my thyroid was on the move. I didn't realise then but the more that I read about [the anxiety attacks, the more they] pointed very strongly towards menopausal symptoms.

I used to be able to get through quite a lot and [now] I couldn't cope with it and [it seemed to be] all tied up with thyroid again but that could be age as well couldn't it? I just used to fade out before. I was just so tired or I felt so tired but again some of that was tied up with the stress of not coping... I [asked] friends who [had been through menopause] could it be menopause? As soon as I went on to HRT quite a lot of these things just disappeared.

I have some reservations about [HRT] but at this point in time I am not game to give it up and try to go back without it. I guess I may be wrong... I was more positive about [HRT] because of all the people I had met in Scotland and Australia that had actually gone on to HRT long before I had ever considered the need or the possible need... they seemed to be coping... my sister-in-law in Scotland said some of her friends said 'I'll kill anybody who takes this away from me' and now I could subscribe to that... but at the same time I think I would always keep monitoring. I had a mammogram done because I know there is a history of breast cancer in my father's family [and I know HRT increases the risk of breast cancer] so I wanted to be reassured at least on this point that I was okay... for my own peace of mind.

Well [menopause has] been a bit spoilt because of the symptoms that came along with it. I thought it was going to be positive and I thought it will be really good to be able to... forget about menstruation. Not that that was ever a problem... and I thought, 'Oh this is nice and tidy' but that's where the positive part finished for me because I really didn't feel good at all...

I don't know that [other women always] realise that the hormonal changes are going on [at menopause] or the results of these problems... I feel that there is a lack of information... a lot of myth... even in my mind! I thought it would be all over when I am forty-five or something [and] I was really surprised when a lady said to me 'Oh don't count on it... I wouldn't say I am over it and I am fifty-eight'. I thought of the shorter time-frame that you might get through this... Because I do remember people at meetings and even at special occasions and they were

going 'Oh, not again! This is awful!' ...and I didn't have a lot of hot flushes but maybe it was coming out in other ways. I wonder how many people just don't get symptoms...

### **Paula: Feeling Robbed**

Paula, a forty-three year old, *NZWD* respondent from Taranaki, sent the following notes which describe the impact of her unanticipated, early menopause.

-no symptoms at all except over a year, irregular periods which were lighter than normal and sometimes spaced further apart. I'd gone through a shift from Australia to New Zealand and put it down to the 'trauma/stress' or after-effects thereof. Plus I was also diagnosed at the age of thirty-two of having mild MS [Multiple Sclerosis] and at the time put it also down to that (not knowing enough about MS and the effects it could have on me).

-visit to the doctor after this year of irregular periods, still no symptoms. Doctor tells me I'm too skinny - put weight on - periods will come back.

-six months later and a little more weight on I go back again. Agrees to some blood tests.

-another two months later - results mucked up - have to have another lot done (tests have to go to Hamilton).

-another two months later I'm told I have abnormally high FSH [Follicle Stimulating Hormone] levels, so high the doctor doesn't believe it and wants another test done.

-another few weeks/months down the track the test comes back high but lower than the other -nothing else is suggested. I'm told that it may be possible but not likely that it could be menopause. In fact the doctor thinks instead of MS the high FSH level may indicate a tumour in the Pituitary Gland (symptoms similar apparently) so I wait for a scan. Scan normal. Another test for FSH levels done - this comes back abnormally high.

So the doctor decides after all this time - I think by now I'm about thirty-eight years old - yes it probably is menopause after all.

The doctors were helpful, patient but I'm very disappointed that the last few years of my 'possible' childbearing years counted for nothing. I'd had one daughter at the age of thirty and by the time the doctors had finished mucking around deciding what was wrong with me I felt that the last chances of having any more children were gone. From time to time I still feel sad about that (-an ex-teacher and love kids). If only I had known my grandmother went through menopause at thirty-five years of age! My mother had a hysterectomy in her early thirties so I found out about my grandmother only after my problems were finally diagnosed.

I didn't at the time realise the implications (i.e. no more children) of what was happening to me. I would admit to feeling robbed of some better experiences in my life. I expected to go through menopause at fifty. I feel like a sexless wrinkled up prune sometimes but on the other hand I had no real problems with menopause - no real symptoms or problems. To put it a little better - I am having to reconcile myself with being now what I thought would be at least ten years down the track.

### Sue N: A Natural Process

Sue N, a forty year old, *NZWD* respondent who worked as an administration officer and receptionist in a lower North Island provincial city, wrote of her views on menopause and her expectations as follows:

I don't think I have entered into the menopause as yet, however it is a subject that obviously will affect me sooner or later. I think I will be around fifty when I start, as that's the time my Mum did. [I] expect to experience symptoms like irregular periods, hot flushes, mood swings and weight gain.

I see [menopause] as a natural process that has both positives and negatives. All my female relatives seem to get quite heavy, especially in the lower half of [their bodies] after menopause, although they are active and exercise regularly. While I am not really figure conscious, I am very short, 5'1', and have a definite pear shaped body... if I am honest I am slightly overweight (61kg) and don't want to get heavier.

I hope I don't need HRT. Many of the benefits that HRT is supposed to produce I appear to have already (e.g. my paternal and maternal grandmothers lived long, healthy lives). My great-grandmother died at ninety-six, my maternal grandmother is still alive at eighty-four. So far I have not experienced any deaths of a female relative in my family apart from my paternal grandmother who died at seventy). I have blood that doesn't clot very well and my doctor says I am not a likely candidate for strokes and heart problems. The one thing I do experience, and females in our family are susceptible to, is headaches. I do get migraines and have since I went into puberty. I can manage them through natural means and only have about two a year where I have to take to my bed. I do worry that menopause may increase either the intensity or the frequency of migraines.

I work in a predominantly female staff so therefore menopause is just part of life with its joys and frustrations and is talked about normally. I have encountered very sexist attitudes from older (male) relatives in my family and my husband's. I actually think a lot of men can't cope with 'the change' in their partners because it makes them realise they are getting older too. My parents split up about the time I guess my Mum was going through menopause. It was sad really because Dad tried to understand... but I don't think either of them knew how to communicate about the processes they were going through. I should say I don't really think menopause caused my parent's marriage to break up, but I do wonder if it could have had a bearing on the way Mum was feeling at the time.

I don't really fear the menopause from the point of view of the reaction from my husband. I think it is just another process we will deal with together and communicate freely. I do hope our sex life is not adversely affected but I am sure if there are problems where sex is concerned we would try and work it out together or seek appropriate help. I don't expect any problems.

### **Mary Ann\*: A Process Rather Than a Problem**

Mary Ann\* expressed interest and enthusiasm for the research project and offered to join me at my home early one summer evening for a recorded interview. Forty-nine year old Mary Ann\* portrayed a sense of the immediacy of menopause. In response to my question of whether she looked forward to menopause, Mary Ann\* replied:

...absolutely. I hate periods. I just hate them. It's not sad whatsoever. No definitely not...by the time I get to [menopause] I [will] be so bloody relieved...it can't come quick enough as far as I'm concerned.

If I have any trouble [with my health] I just read first of all. I just hit all the books. I have got a woman's health file because I have had menstruation problems my whole life, so anything [connected] with that system I tend to watch for and if you read about menstruation and different cycles...eventually you will hit something else. I generally go for [material] that is actually research based.

The doctor has been trying to give me a hysterectomy for years, just for bad periods but there has been no cancer. To me, unless I have got cancer, there is no point in going in and having major surgery because there are more dangers to surgery than doing nothing as far as I'm concerned. A lot of friends that I know say, 'Oh I am going in for a hysterectomy. I have had enough of this. No more periods'. Maybe they are making the best of a situation. I don't think I have had symptoms bad enough...maybe if I was desperate and I was suffering...[but]...I thought, 'Well I have been having that since I was ten so I mean hysterectomy is not going to solve all that'. I read all the stuff on hysterectomy and decided to forget it. Wait until mother nature does it. Hang out.

I had a vague notion [about menopause] and so when my Mum died in about 1988 I started skipping periods and I started [thinking], 'Well is it my age or is it something else?' and those kinds of things. [When menstruating] I just had terrible cramps, fainting away, problems my whole life...heavy bleeding...accidents, everything. It probably didn't change until I started skipping about 1988...so I don't know if it was actually menopause or changes or whatever, or if it was just stress. I was probably just over forty, forty-one...so I think I was a bit young for troubles to start then you know. You think you are too young and you read it could happen with stress. Then [the period] kind of re-establishes itself. Every time I would stop and start again I would think, 'Oh blow it! Just go away!'. [Menopause] couldn't be any worse [than menstruation].

So the periods have been changing over time. The pains have been changing...different...my colon actually started cramping up every period when I actually get such awful pains. Instead of the uterus I was getting cramps in other parts of my stomach...my whole legs would cramp up, right up the back or down the thighs...and the heavy bleeding. Then I would get all the PMS and the headaches and backache...[for] three or four days. Once you start flowing well then it is better but until you do then I just went through hell. I have actually been so bad that I couldn't leave home and then when the flooding starts you went through a stage when every twenty minutes for two days I would flood. It has actually stopped. Well I am having a period about every three months...so I presume that I have just about hit menopause.

I think a lot of the HRT stuff is the fountain of youth stuff. That no matter how old you are your body is going to change and if you start looking for youth all the time and start taking all that stuff, all you are trying to do is delay the inevitable. So you might as well learn to live with it. You know I hate my thickened waist and the shape of me when I look in the mirror but its not going to go away, no matter how much exercise I do I am going to have a different shape than what I had when I was twenty-five. Such is life!

### **Nora\*: Part of Life**

Nora\* is a thirty-seven year old farmer's wife and mother of three young sons. She shared her views and expectations of menopause with me over a cup of tea, while sitting at her dining room table:

I often think it is [somewhere between the ages of] forty-five and fifty when women go through menopause. Surprisingly, a number of younger women seem to be hitting [menopause] or having hysterectomies in their early thirties, which always quite surprised me when you hear of one because I wonder if that's maybe a side effect of people going on the pill these days.

I don't dread [menopause]. I mean its one of those things that you go through. I am not exactly anticipating it, looking forward to it with bated breath exactly but it is just part of [life]. I hope I don't have a very long menopause because it makes life difficult. You can't plan and you get sudden flushes and things like that and having watched that I think that cannot be easy. It must be very embarrassing if you do get embarrassed easily but its just part of human life.

Mum had a terrible time...she just used to flood and there were days when she could barely do [anything, when] she had a pad and then hand towels folded up...she just flooded constantly for days and days....I helped Mum and I watched Mum and I remember what a relief [menopause] was for her. I mean she didn't have a very easy hysterectomy either and she was weak for a long time [but] I don't dread it [but] I keep thinking does this mean that I am going to be a dried up, wrinkly old hag, etc.? That's just a stereotype idea...but its the big hype isn't it, that you want to be young and youthful and get HRT? Its the culture that is thrown at you. [I] think of all the people I do know that have been through it, like my mother-in-law for instance. It was a blessing for her when [menstruation] finally finished because she had a long, long time where it would just keep coming back and with the flushes it drove her nuts. But I mean she is doing just as much or more as ever she was and she looks better in jeans than I ever did, that's for sure! Its the young psychology...and I don't know whether women in town are more prone to it than out here, because out here you just go with the flow. I think in this day and age people are driven to look perfect all the time. Be the perfect everything, wife/hostess. I think for a lot of people [HRT] would be the way of preserving what you used to be maybe instead of thinking that [menopause] is all natural.

I don't think I would take [HRT, unless] the doctor recommended [it]. My doctor doesn't give out pills easily for anything so...if he recommended [HRT] it would be because he thought you needed it...But I think if [HRT] was medically recommended because...you were going to be so hormonally unbalanced that you were going to have terrible mood swings and it was going to affect you, that's different. I would then [go on HRT], but not

just for vanity's sake, because I mean growing old is growing old. That's part of life like before your periods, then you first get them and when you are having children and when you finish them and life after that. It does go in stages.

I am expecting the freedom of not having periods. That would be wonderful only because a side effect [of periods] for me was that I got eczema which I never had before, mostly here [genital area]...of all the places to get it! So you can imagine if you have got your period and its a super heavy one...you get this sort of chaffy itch and its uncomfortable...so not getting your period and not having that [will be great].

...I know that I don't want to keep taking the pill. It strikes me that fourteen years is quite a long time to be on the pill. I mean I had breaks in between when I went off [the pill] to have the children. I ought to get my tubes tied. My head says I ought to get my tubes tied because I keep thinking every time my period is late, 'Yippee I am pregnant again!'. Practically I know it would be difficult financially and there is a big gap. There would be seven years if it happened now but I always wanted four [children]. It would be wonderful. I would probably feel cheated [if I went through menopause now] because I keep thinking that up until the age of forty-five there is the possibility [of having another child].

### **Marie\*: It Will be Great**

Thirty-eight year old Marie\*, close friend of Nora\* and resident of a nearby farm, talked with me in her large, remodelled farm-house kitchen. Nearby her youngest (pre-school) son played quietly.

I don't know quite why but [I have experienced] vast amounts of changes in the last eighteen months to two years than there ever was before, basically since puberty really. I have that distinct feeling of [winding down towards menopause]. That is certainly how I have felt in the last probably two years. Like my skin has changed dramatically. I don't think it is because I have had four children and have been quite sort of stressed. I know I now have to be very conscious if I want to look my best that I have to have a decent night's sleep (which is not always easy) and that you put your moisturiser on and you do things like that. I mean it is a distinct ageing process.

I get sore breasts now [before periods] which I never used to. Usually for a week or so [before hand]. It's changed, actually it's changed a lot when I think about it in the last two years. Like a heavier period to start with and with marked PMS and it is not always the same every month. I mean this last month it has been particularly bad. My husband picks it up immediately, he can tell. I mean they can see the signs a mile off, more than I can. Well I know I am doing it. You can tell when you get up in the morning when you are probably at your lowest ebb that things are going wrong and you yell at somebody when you don't really mean to yell at them and then it suddenly occurs to you about three days later when you have dissolved into tears over something pathetic that there is something up.

At least I know when I get my period that in three or four days time it is going to be gone [and that] its going to be quite heavy for a couple of days. I mean it is just like it pours out...and certainly for the first day I make sure I don't leave the house. When [Nora's\* mother-in-law] suggested [I may be leading up to menopause] I laughed at the time because I

have always said that I really look forward to menopause because you get rid of all this. I was really looking forward to it and I still am. I think it will be great!

We go tramping with an older age group and a lot of them are in their fifties and early sixties and all the women are past menopause and they have a ball. I mean it is actually great. There are a few my age and a couple younger and when you get a period in the middle of the bush, I mean it is a real fag. It really is. You are feeling lousy and you have just got to keep going but I mean these women are having a ball because they are totally free of it all. They are full of beans, they are really having a good time. So I think it is the way you look at it, I think it is going to be great.

Certainly [among] my age group [menopause] is just something to come. We have all said like I have just said, 'Oh it will be really good when this arrives'. We all know that it is the end of the fear of pregnancy thing, which was always on my mind [and] the reason I got my tubes tied. Yes, I sorted that problem out earlier on, having had one mistake I certainly didn't want another one. You don't regret it but it certainly alters your plans and things.

I am sure [menopause is a negative event for some women]. My mother...got quite depressed at the time and complained about the hot flushes...my father slipped in the odd comment...that Mum was a bit down today or she is having a hard time. Things like that. I have two other friends in Feilding. One who isn't married and she is thirty-four, thirty-five. Now she would love to be married and have children but I mean time is running out for her too and she has said that [will happen] if she doesn't get her act together. But she is not going to marry anybody or just have a child for the sake of it. So I am sure it is in the back of their minds. Whereas for most of us who have done their thing, I mean it really can only be a positive thing. I mean we have done the life cycle thing haven't we?

The eight narratives presented above portray a range of perceptions, attitudes and expectations associated with an understanding of menopause as time of mid-life and ageing, loss of fertility, and health risk. Each of these meanings and their significance for the women's views of menopause will now be examined and discussed.

## **MID-LIFE AND AGEING**

### **A Natural Life-stage**

The view of menopause as a normal, natural stage in the female life cycle emerges as a dominant perception in the above narratives and is shared by many of the women in the study. Colleen\* and Sylvia, for example, referred to menopause as 'just a stage, a natural part of your life', 'a normal part of life'. Characteristic of the normal, life-stage view was a general understanding of menopause as being synonymous with mid-life and ageing. Consider, for example, the comments of Annette\*, Ainslie\* and Jackie\* who said:

I just see it as a natural part of your life, but I don't see it in any way liberating and I guess [that is] because it also signifies ageing.

...it is just part of the functioning of your body when you are getting older.

I just see it as part of the ageing process really... puberty is natural, menopause is natural.

Underpinning this understanding of menopause as an integral aspect of the ageing process was the notion of 'natural'. The term 'natural' was readily employed to describe the process of menopause itself together with a range of associated bodily functioning, behaviour and management strategies. It was clear from the women's comments that 'natural' signified a range of phenomena and processes that were deemed to be beyond conscious control and independent of social and cultural forces.

In recent years the promotion and uncritical acceptance of bodily processes as natural, particularly in the area of women's health, has been rigorously challenged by a number of researchers. Haraway (1991), for example, critiques assumptions underlying theory and research associated with contemporary scientific belief on human origins and nature. In particular, her analysis of primate studies leads her to question the ability of science to define and verify phenomena as natural, given and inevitable. Indeed, Haraway (1991:72) is unequivocal in her view that biology 'as the science of life' projects a patriarchal perspective and argues that 'bodies...are not born, they are made' (Haraway, 1991:208.). Moreover, she is at pains to point out that in the latter part of the twentieth century 'the universalised natural body remains the golden standard of hegemonic social discourse' (Haraway, 1992:355). Her point is that the so-called natural body is in fact a manifestation of the body politic; that is, an entity shaped and constrained through socio-historical processes of power and control. Haraway's stance is endorsed by Jacobus et al. (1990:4) who argue:

...we cannot speak of the feminine body as if it were an invariant presence throughout history. There is no fixed, experiential base which provides continuity across the centuries; our perceptions and interpretations of the body are mediated through language, shifting in accordance with the differing ways in which the body is articulated and located within the intersecting and competing discourses of each era.

*natural*

The significance of the arguments advanced by Haraway and others in relation to this study, is that the women's perception of menopause as a 'natural' life-stage unconsciously draws on a myriad of socio-cultural values and beliefs; a clear indication of the nature and role of common sense knowledge. These values and beliefs involve scientific and medical knowledge of the human body and its functioning, in addition to the role and status of women throughout the life cycle. Indeed, the perception of 'natural' as an entity independent of time, culture and consciousness embodies a fundamental assumption of the Enlightenment - namely that nature is independent of culture. Seen in another way, the women's recognition of menopause as a natural event both challenges the body politic by promoting an alternative to the deficiency disease, and at the same time assumes the unmediated status of 'natural'. In other words, the women's views represent an attempt to refute the disease model through reconstruction and exertion of control over a process they perceive as a 'normal' and inevitable stage in the female reproductive cycle (Estok and O'Toole, 1991:31).

While the perception of menopause as a natural life-stage is fundamental to the views presented in the narratives at the beginning of this chapter, the women nevertheless exhibit a variety of attitudes towards this event. Jacky\*, for example, sees menopause as something to be coped with by adopting the 'right' (i.e. a positive) mental attitude despite a fear that the menopausal transition could result in a loss of attractiveness associated with 'becom[ing] an old woman'. Likewise, Kath\* felt that if she adopted a positive attitude she would be able to 'ignore' menopause and 'let it pass by', although her experience left her less positive about this event which she subsequently perceived as a time of health risk. In contrast, the emphasis placed by Pat and Paula on loss, sadness and lack of control over physical changes which are indicative of ageing, decrepitude and diminished femininity, convey a negative stance. Moreover, the largely positive attitude of the remaining four women is compromised by their negative perceptions of anticipated and/or actual bodily changes. Sue N, for example, is anxious to avoid acquiring a 'heavy...lower half of the body after menopause', a trait she has observed among her female relatives. Mary Ann\* expresses her dislike of a 'thickened waist' and altered body shape, while Nora\* and

Marie\* are apprehensive over the possibility of a shrivelled, wrinkled and dried up appearance. These expressions of apprehension and/or negative perceptions are not surprising as they reflect a youth orientated culture and the social pressure placed on mid-life women to retain their youthfulness and (by definition) sexual attractiveness.

### **The Ethic of Stoicism**

A common attitude associated with the recognition of menopause as a normal, natural life-stage was the view that women should 'just get on with it'. A number of the women, particularly older and rural women, held or encountered attitudes which conveyed little sympathy for those unable to stoically endure physical discomfort attributed to menopause. There appeared to exist also a common perception that many problems associated with menopause were 'all in the mind'. The comments of Sally\*, Marion\* and Monique were typical of such a view:

[Menopause] is just one of those things that happens and [you need to] get on with it and [then] you can get on with your life. I don't think it is some great huge something sitting out there waiting for you...there are plenty of other things that are more traumatic...

I think to be quite honest there is too much talk about this sort of thing. I listen to Kim Hill [on National Radio] sometimes and think, 'Oh what a lot of blabber! Just why not get on with life? Do something else. Let your bodily symptoms fade into the background'. There's a lot made of it by the Sandra Coneys of this world!

The right mental approach and a strong mind can help you deal with things a lot better.

Beth\* and Joyce\*, on the other hand, recounted the pressure felt by many women to keep going without complaint:

...there may not be that feeling now, but there used to be [the attitude, that if] you can't put up with it, you have got no backbone. You [would] get [comments such as] 'Pull yourself together, you are not the only one'.

...if [women] are busy [they] just carry on and think 'Oh well it is part of life'... [it is just a weakness] if somehow you give in.

The women also encountered similar attitudes among husbands and male family members and friends. Anne\*, for example, said that her husband explained her severe night sweats as 'psychological' in origin, while Jacky\* pointed out that she knew:

...some men who have an attitude that says 'Oh she has got a mental problem'....I am talking about the chauvinistic type of men and I think it has an important part to play in how a woman reacts. If [a woman] is married to a man like that...she wouldn't want to do anything or say anything that could suggest that she is going through menopause...

Other women's attitudes reflected their observations of close family members. Helen\* and Sue\*, for example, had witnessed their mother's behaviour at menopause and were determined 'to get on with it':

Well seeing my mother...when she had a [hot flush]...she would get something out and fan herself. I thought I would do nothing that would draw attention [to myself]. You know, if I am going through [menopause] I will go through it as quietly and as unobtrusively as I can.

Dad said that my mother said that she sailed through [her menopause]. She may have sailed through it, we sure didn't! So I am determined that my menopause is not going to get in the way of anything.

Attitudes to menopause expressed through the ethic of stoicism can be understood as a manifestation of the body politic via common sense knowledge. Indicative of the body politic as the ability to exercise power and control is the notion of deviance, which in this case implies a failure to conform (Lock and Scheper-Hughes, 1990:50). As a manifestation of the body politic, the notion of deviance emerges in two forms throughout this discussion: first, in the form of social deviance involving women as agents; and second, in the form of physiological deviance with respect to the 'universalised natural body' (Haraway, 1992:355). In the case of the ethic of stoicism, it is the notion of social deviance that constrains the women's behaviour and views.

Chapter 5 identified a climate of inhibition or reluctance to raise the subject of menopause between mothers and daughters and it was suggested that this in turn constrained how their common sense knowledge was shared. If symptoms were experienced under such conditions they were likely to be attributed to other factors. Against such a background the presence of an ethic of stoicism and perception of symptoms as a product of the mind is hardly surprising. Indeed, Lyon and Barbalet (1994:54) note:

...the human capacity for social agency, to collectively and individually contribute to the making of the social world [which] comes precisely from the person's lived experience of embodiment.

Accordingly, the ethic of stoicism can be understood as a remnant of a collective ethos born out of ignorance and taboo; that is, a socially derived but experience-driven attitude of personal fortitude during menopause which generates expectations of similar behaviour from others. Women heard to complain under such conditions, women who do not exhibit the 'right' mental approach or who fail to 'get on with it', are regarded as socially deviant. Indeed, Estok and O'Toole (1991:32) point out that research on North American women has identified the belief that a number of symptoms commonly associated with menopause are 'believed by some to be subject to [the woman's] control...or so minor that a person should keep them to themselves and not bother others'. In such cases, the woman 'would be held responsible for minor deviation'.

Looking beyond the attitudes and expectations of women themselves to those encountered in the wider community, the explanation of female behaviour in terms of reproductive processes implies deviance through physiological and psychological inferiority. Such a view reflects the hegemonic notion of the 'universalised, natural body' derived from the standard of the 'unmarked masculine' as a neutral entity (Haraway, 1992:357). In other words, the perception of women as enslaved by their hormones and as the victims of pathological decline at menopause reflects an assumption of male physiological stability as the norm. From this perspective, the hormone-driven, menopausal body as the biological 'other' is not only deemed physiologically deviant but becomes fair game for male 'put down' as will be demonstrated below.

A number of participants drew attention to derogatory comments frequently made by men about menopausal women. It was not uncommon, for example, for these comments to take the form of jokes which mocked women as inferior on the basis of their reproductive functioning. A perception of menopause as a marker of decline in mental and physical ability was also a recurrent theme. Beverley\*, for example, recalled an occasion from her childhood:

...it must have been at the time Nana went through menopause. I can remember [my father] saying, 'Don't worry if the pudding doesn't taste too good, your grandmother will have forgotten to put the sugar in', and how she was losing her memory and like she was getting

la la! I can remember all the men at home of the older generation, and even my husband, sort of looked on it as being a bit, you know, nudge, nudge, wink, wink...it was never spoken about in a positive way for the [women] who were going through it.

Trisha\*, Bella\* and Bobbie\* encountered similar attitudes:

I think [among] men of my generation, my girlfriends' husbands and my husband, it is a bit of a joke. I think they are perhaps a bit more understanding than perhaps old guys were, but it is still a bit of a joke...if you say something or snap at them [the retort is] 'Oh she's a bit hormonal!'

There's a lot of derogatory remarks made by men about these things, but it is probably because they don't understand what's happening with the women.

You do get joking references about hot flushes in mixed company. [Statements such as] 'Oh it's just menopause, she's getting hot flushes' sort of business. A put down sort of thing. 'Oh don't worry about her, she is just being moody!' It's that type of thing, and I think it is more from men.

### **The Evolutionary View**

The common sense assumptions of biological inferiority and physiological deviance implicit in the men's comments are also apparent in the evolutionary perception of menopause. The naturalistic observation that women are the only mammals unable to produce offspring throughout their entire adult life, together with the assumption that in earlier generations women commonly died prior to menopause, underlie the evolutionary view. The result is a recognition of menopause as an unnatural and therefore physiologically deviant state. As will become evident in the following chapters, such a view allows for medical redefinition of menopause as pathological, that is as a disease of oestrogen deficiency.

A number of the women viewed menopause as part of the process of evolution. Sue\* and Colleen\*, for example, believed that the present generations of women were the first to regularly survive past menopause, while Trisha\* (an avid reader) provided the following explanation as to why menopause occurs in mid-life:

...mother nature's big boo boo! ...we are actually going through [menopause] earlier than we should because we didn't use to live very long, so it was [at] the end of your life that you went through menopause. Now women are living twice as long [and menopause] is coming in the middle of your life instead of at the end...they reckon that it may be when we are older and older and more evolved that we will [go through menopause in old age].

On the other hand, Jackie\* felt that an evolutionary view explained why women did not talk about or cope well with menopause:

... simply because it is only over the last century... that women have lived to an age of being able to go through menopause anyway. Historically speaking, most... had died by the time they reached forty. Before the advent of hygiene and stuff like that women died and men used to have several wives, lucky them! I [have] read [that] women... started childbirth probably when they were about fourteen or fifteen and by the time they were thirty they were like old hags. They were worn out. So we never got that far [and]... so [menopause] didn't become something that... [women]... even realised was happening...

Not all of the women, however, were convinced by the logic of the evolutionary view and some, such as Beth\*, questioned essentialist arguments about what it is that constitutes women's existence:

Do you think that perhaps when we get too old to have children, too old to bring them up, too tired or whatever, that we were *meant* to die?

The perception of menopause as an enigma in the process of human evolution needs to be recognised as a perception overlaid with social assumptions concerning the nature of scientific knowledge, the role and status of women, and fertility and ageing. Haraway (1992:4) reminds us that as a culturally specific way of knowing:

... the history of science appears as a narrative of the history of technical and social means *to produce the facts*.<sup>3</sup> Scientific practice may be considered a kind of story-telling practice - a rule governed, constrained, historically changing craft of narrating the history of nature.

Fundamental to the evolutionary explanation is the assumption that observation of the animal world can be extrapolated and applied in the human arena. In the case of menopause the result is a biologically reductionist argument centred on woman's ability to propagate the species. Aside from being teleological and simplistic, it is the total disregard of the 'dialectical... relationship between biology and culture' that is the most unsatisfactory and indeed confusing aspect of the evolutionary perspective (Davis, 1996:70). In other words, as a scientific explanation, the evolutionary view of menopause does not present 'an unmediated natural truth of the body' (Oudshoorn, 1994:3). Instead it reflects and substantiates the received wisdom on women, their fertility and the process of ageing.

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<sup>3</sup> My emphasis.

To sum up, this section has identified the concept of 'natural' as fundamental to the women's views of menopause which most perceive as a normal stage in the female life cycle. The ability of the body politic to exercise power and control over individuals and social groups is evidenced by socially and culturally defined notions of what constitutes social, psychological and physiological deviance. In the case of social deviance, the ethic of stoicism and a dismissal of menopause-related complaints 'as all in the head' provide examples of its impact on women as agents. Hegemonic acceptance of the 'universalised, natural body', on the other hand, underlies the perception of the female body and its reproductive functioning as physiologically deviant. Evidence of the latter emerged through male jokes, a 'put down' of mid-life women and the view of menopause as an enigma in the process of evolution.

Finally, despite the arguments presented above, there is a further point that should at least be acknowledged. Given the constraints on the sharing of common sense knowledge which allows privilege to be accorded to medically dominated knowledge, the implications of a popularised view of menopause as a universal disease of ageing becomes ominous.<sup>4</sup> If menopause becomes accepted (within both the medical and common sense models) as an unavoidable state of decline, decrepitude and sexual neutrality which (despite the intervention of synthetic hormones) affects women relatively young by today's standards, then surely it represents the type of loss and marginality for women described by the writer of 'War Widows of a Kind' (Anonymous, 1986). Or does it?

## **LOSS OF FERTILITY**

### **End of menstruation**

From an evolutionary perspective, the end of fertility is viewed as a biologically deviant and socially negative aspect of the human female's reproductive functioning.<sup>5</sup> The majority of the women, however, viewed menopause as a normal life-stage and an integral aspect of the female reproductive cycle. Trisha\* and Nora\* demonstrate such a view:

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<sup>4</sup> See Chapter 5.

<sup>5</sup> See Haraway (1990) and Lock (1993).

... [menopause is] a life thing. It's a stage of life that has its compensations and its problems, just like periods have theirs... it comes and [like] everything that happens in your life, it all has its pain and its good.

[Life]... does go in stages. Like before your periods and when you finish them and when you are having your children and when you finish them and life after that. It does go in stages.

The significance of the life-stage view of menopause was also evident in the comparison frequently made between menopause and menarche. Most had a clear memory of their first period which was often a dramatic event characterised by taboo generated ignorance, as well as fear and horror over hygiene arrangements. Betty\*, Catherine\* and Norma\*, for example, remembered that:<sup>6</sup>

I didn't know until I had my period. [I] knew nothing about it, nothing. I sort of stuffed my pants with rags and things and my mum, when she saw, the only thing she said was, 'Now you are growing up. You are no longer a child!' I thought I was dying and it gave me such a complex. The sanitary belt appeared plus the pins. They used to use those barbers towels...[which were] soaked [in cold water]... with salt... I just thought it was dirty.

...it was night time [when I] got it and [I] woke up in the morning and had blood everywhere and I thought I was dying. I was frightened, wondering what was going on... and I went in to say something to my mother. She said, 'Go and tell your father'... he threw me a baby's nappy and said 'Use this between your legs'. That was it! I didn't know anything that was going on.

I was bought up by my grandmother and my sexual knowledge was, 'Are you all right?' and I used to go, 'Yes I am all right'. I think that meant had I started my period because when it did start I was convinced that I had done something terrible, cut myself and something or other and I was too scared to tell anybody for two days. I thought I was bleeding to death. I was convinced!

Little wonder, given the trauma of the first menstruation, that many of the women in this study perceived the end of menses as a positive event, a welcome release from the inconvenience, embarrassment, mess and discomfort of monthly periods. Such a view is also documented by Wear (1993:591) in her examination of literary accounts. But the prospect of an end to menstruation for many of the women signalled more than just liberation from menstrual blood. The freedom from a monthly cycle involving mood swings (often attributed to pre-menstrual syndrome [PMS]), ovulation pain, recurrent

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<sup>6</sup> As explained in the previous chapter many of the participants commented that matters relating to female reproductive processes, including menstruation, were never discussed by their mothers, within the household or even among peers.

migraine that restricted activities, as well as actual menstrual discomfort, was commonly mentioned.<sup>7</sup> As is evident in their narratives, both Mary Ann\* and Marie\* are unequivocal in their views about the benefits of the end of menstruation. For Mary Ann\*, it offered the prospect of relief from years of severe, disruptive menstrual pain and discomfort. In Marie's\* case, recent episodes of heavy bleeding, increased severity of PMS and a tubal ligation on the completion of her family, meant that she regarded menstruation as an uncomfortable and redundant inconvenience. She looked forward to menopause as the time when she would be able 'to get rid of all this'. Similar sentiments were expressed by other women. Gail\* and Kath, for example, noted:

I used to have a lot of problems with my breasts. [They would get] terribly sore and terribly hard for at least three weeks out of the month and that was a terrific release not to have that. I felt really good about that.

Four or five years ago I started getting three day headaches that would keep me in bed if I didn't have 'Codral' pain killers. I visited the doctor and she said it was probably my age, so I just kept on with the 'Codral'. During this time my periods also became a bit erratic and I thought, 'Yes, they're going to stop'. Great jubilation! I've contemplated a menopause party! My doctor told me I should be 'period free' sometime this year. I look forward to it greatly.

In fact, a surprisingly large number of the women indicated that they had endured years of menstruation-related health problems, the most common being recurrent migraine. Beth's\* experience, for example, although among the more severe, was not unusual:

I used to get a migraine every month with my period and that was one [good] thing about the menopause, they got considerably less and now if I get one it is very rare.

I would [often] be standing [at work as a bookshop assistant] waiting for half past five to come so that I could go home. When I got home I would go to bed and I would be no good. I would vomit and I perhaps had to stay home the next day. That happened every time I had a period and sometimes in between...they are awful.

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<sup>7</sup> Davis (1996:58) notes that PMS was first identified in the medical literature in the 1980s as: 'a psychoneuroendocrine disorder. The term refers to the cyclic reoccurrence in the later luteal phase of the menstrual cycle of a combination of distressing physical, psychological and behavioural changes of sufficient severity to interfere with normal activities'.

Marion\*, who like Marie\* experienced heavy bleeding following a tubal ligation, was also delighted to reach the end of menstruation.<sup>8</sup>

I had a tubal ligation when I was forty. I couldn't take the pill and we didn't want any more children, having four. So I had the thing done. No-one warned me that flooding was an off-shoot from that. It got really bad just before the cessation really...every month for two or three days. I have always been involved with community affairs and so life was pretty busy and that sort of thing had to be coped with. It was no good saying to someone, 'Oh no, I can't do that today because I am flooding'.

For some of the older women the attainment of menopause also bought relief from unwanted pregnancy. Marion\*, for example, noted that pregnancy was a:

...big fear [when] women [were] approaching menopause because your periods become irregular and you don't know when you have a safe period or not.

Betty\* remembered being worried about the prospect of a late baby, particularly in light of problems at birth with her second child:

...all the time you think you could get pregnant. That's the only good thing, you thought once menopause was past you couldn't become pregnant. A decided relief particularly when you have been told not to have any more [children].

The fear of pregnancy, however, was not exclusive to older women. Younger women such as Louise\* were concerned that:

...when your hormones are all up the twerp [sic] and you are missing periods, what happens if you are taking the contraceptive pill?

A small group of the women, however, held ambivalent or negative feelings at the prospect of the end of menstruation. Generally such feelings were accompanied by a sense of loss or sadness at the closure of this stage of their lives. The narratives of Pat, Nora\* and Catherine\* indicate such feelings. Pat, for example, lamented that she was 'no longer linked to the rhythms of the moon, no longer biologically necessary' and missed the sense of well-being that followed her monthly period. Nora\* did not feel ready to relinquish the possibility of being able to conceive another child despite looking forward to the end of the discomfort associated with menstruation. Catherine\*, a woman who devoted her adult life to her family, commented she could see no advantages in menopause:

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<sup>8</sup> Approximately one third of the women indicated they had either had a tubal ligation or their partner had undergone a vasectomy. For these women the loss of fertility was not an issue, although as Marion's\* comments illustrate, the end of menstruation was.

...put it this way, you know I am funny. All my life consists of is my kids and my grandchildren. If I had my way and if I could have another baby and breastfeed it, I would. I love my babies, I really love my babies.

Indeed, the end of fertility emerged as an issue for a number of women. Joy\* articulated it this way:

I did sometimes think that when you realise that you can't ever have any more children, not that I was planning to, it just seemed so final.

For women like Lorna\*, who had started a family in her late thirties and hoped to have another child but also suffered severe 'monthly' migraines, the prospect of the end of menstruation generated very mixed feelings:

[I] would just enjoy not having periods because it may eliminate migraine, hopefully. Because I get them before a period and I would welcome that, but then again if you are still wanting a baby you might find that it gets quite distressing.

Perhaps the most graphic example is presented in Paula's narrative which indicates her sense of loss and grief when the end of menstruation signalled an undiagnosed, natural but premature menopause.

...I'm very disappointed that the last few years of my 'possible' childbearing years counted for nothing. I'd had one daughter at the age of thirty and by the time the doctors had finished mucking around deciding what was wrong with me I felt that the last chances of having any more children were gone. From time to time I still feel sad about that (-an ex-teacher and love kids). If only I had known my grandmother went through menopause at thirty-five years of age!

To sum up, it is clear that the expression of ambivalent or negative attitudes with regard to the end of menstruation relate to the loss of fertility, but not always for exactly the same reasons. Underlying the views of Lorna\* and Paula was a desire to have a larger family. Catherine's\* comments identify children and childbearing as the central source of pleasure and satisfaction in her life; being a mother is perceived as her role in life. Finally, the comments of Joy\* and Pat convey a sense of powerlessness in the face of a biological process over which they have no control and a decline in their sense of personal worth as women. The latter perception appears to reflect wider social attitudes which classify the human female as physiologically inferior and an enigma in the evolutionary process as well as the essentialist notion of womanhood as constituted by fertility and the ability to reproduce.

### Ageing in a Youth Orientated Culture

Lock's (1993:334) observation that middle-aged women are 'compared to their detriment with younger, fertile women' was echoed in the remarks of a number of the participants and *NZWD* respondents. Anne B\* and Trisha\*, for example, said:

Well I guess... that's the power of advertising... older women are not seen as attractive.

You do feel a bit discarded... when you get a bit older, into the forties because you are not young and beautiful... and you are not having babies any more...

Viewed against the standard of youth, characteristics of the mid-life female body such as the greying of hair, altered skin tone and body shape, together with the decline in fertility, are deemed socially and sexually unattractive, and undesirable. In other words, the ageing female body is viewed as redundant and doubly deviant through its failure to conform to the standards of both youth and the 'unmarked male'.

The stereotyped view of older women as sexless, desiccated and decrepit emerged in a variety of comments. Paula, for example, remarked that since going through her early natural menopause she sometimes *felt* like a 'sexless, wrinkled up prune'. Marion\*, while pleased that she had not turned 'into a wizened heap', commented that some women 'seem to dry up'. Nora\* indicated a concern at the possibility of becoming 'a wrinkled up old hag', while Trisha\* was the most explicit about her perception of bodily changes related to menopause:

I don't want the hairy chin and the horrible other bits that go with it... things like the skin coarsens. I mean I am getting wrinkly now and I feel I hate it and I am getting puffy up here [around the eyes] and all those physical things. It seems to be tied up with [menopause]. In my mind you suddenly become this drier thing. Suddenly everything dries up, fertility as well as skin and the full bit.

Despite such fears, the stereotypical post-menopausal dried up old hag seemed to be an illusion. Although Paula admitted sometimes feeling 'sexless' and 'dried up', she was unique among the women in expressing such sentiments. A number of the women did, nevertheless, allude to menopause as the gateway to physical senility and social death. Rosie, for example, noted her friends:

...still regarded [menopause] as a subject for older women. Admit to the symptoms and you're past your 'use by' date!

Similarly, Jacky\* admitted:

The only thing that I probably thought was [a bit scary about menopause] was that you probably became an old woman. Like you get to the gate of menopause and you go through it and you are an old woman.

However, while fearful of such an occurrence, none could point to a friend or acquaintance whose appearance conformed to the image presented above.

Although most of the women associated menopause with ageing, a number also viewed mid-life and menopause as a time of freedom from the insecurities of youth and of diminished family responsibilities. Some, such as Ainslie\*, drew attention to their delight at a new found sense of self-assurance:

I am actually enjoying my forties... for the first time in my life I have got the courage to tell people I am not doing [what they ask of me and] I don't have to tell them why! I feel confident in myself. I have stopped letting people walk all over me which I used to let them do. I am not rude to people, I just quietly say 'No' and I have learned to say that without feeling guilty!

Similarly, Trisha\* and Lorna\* present a positive view with their expectation of the post-menopausal period as a time of energy and zest:

I keep hearing people talk about the positive things that give them a new lease of life... they felt healthier, had more energy.

...it is like a new lease of life. You get more energy, feel better, more randy. Some women say they get a new sex release.

But such views were tempered by the recognition of menopause as a biological marker of ageing with far reaching implications in the context of a culture which worships youth.

Avis and McKinlay (1991:65) point out that:

According to the popular view and many experts, the menopause... signifies the end of reproduction in societies such as the United States where sexuality and reproduction are considered evidence of personal success and fulfilment. The menopause is even seen as a major negative event of the same magnitude as, for example, job loss or loss of a spouse.

In these terms the women's fears signal an acceptance 'that mature women are by definition unattractive and all signs of ageing should be disguised' (Saltman, 1991:117).

The flaw in such a view, of course, is the lack of acknowledgement of ageing as a process which eventually manifests itself in everyone and, more significantly, does not as a rule suddenly occur the moment a woman passes through menopause.

This view of menopause as a biological marker of ageing (derived from common sense knowledge based on personal observation, shared understandings and essentialist notions of womanhood) appears to have fostered an expectation that it would occur only within a narrow age range, that is when a woman reached her early fifties. As a result, women in their late thirties and early forties regarded the onset of menopause as still some way off, an event affecting only 'older women'. Jacky\*, for example, remembered feeling this way:

I used to flick over that part of magazines, it was for older women...it seemed not to concern me, even though it was going to happen.

Those women who experienced early signs of menopause, therefore, commonly reported an initial reaction of horror and denial, a feeling of being 'too young' to go through menopause. Ainslie\*, for example, who first experienced night sweats while still in her early forties, said 'I really didn't think I was old enough. I kept thinking this isn't for me at this stage...it can't be yet!' Ainslie's\* doctor shared her perception of being 'too young' while friends commented, 'Don't be stupid, not at your age'. Others such as Anne\*, Trisha\*, Gail\*, Janice\* and Shona indicated similar feelings and several mentioned having difficulties convincing their doctor that symptoms were menopause-related.

The perception of menopause as synonymous with ageing is curious when considered in the light of the current average life expectancy of a fifty year old, non-Maori New Zealand woman as around seventy-three years of age.<sup>9</sup> In other words, at fifty such a woman has almost half of her adult life still ahead of her and is situated at what Sheehy (1992:41) identifies as 'the youth of second adulthood'. Viewed in this way the association of menopause with ageing is no more valid than the association of puberty with ageing. Moreover, it may be noted in this context that while female value and worth is deemed to depend on fertility and youthful attractiveness, the gradual decline in the reproductive functioning of ageing men (marked by a lowered sperm count, inability to achieve and/or maintain an erection, and lowered testosterone levels) is downplayed or has been until recently (Vermeulen, 1997:334). Furthermore, overt signs of male ageing, such as balding

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<sup>9</sup> According to Statistics New Zealand (1997b:116) the life expectancy of women born 1920-1921 is 65-73 years; for those born 1950-1952 it is 73.5 years; and for women born 1993-1995 it is 79.12 years.

and greying of hair, are generally considered handsome, distinguished and even sexy. This aberration was observed by Jackie\*, who pointed out:

The men really don't have the same kind of pressure the older they get. I mean look at Paul Newman. I don't know if he still plays the leading man but it wouldn't surprise me. I mean they still run off with the women in all these things but I mean you don't actually see somebody of my age [sixty-one years], except the odd films like *On Golden Pond* or something where old people have romances. They [the women 'won' by older leading men in films] are usually these big, buxom things with big bums and long legs! What we were all like when we were twenty and, you know, getting the guy!

### Male Menopause

An unexpected theme that arose from both focus group and individual interviews concerned the women's observations and comments on 'male menopause'.<sup>10</sup> Betty\*, Joan\*, Mary Ann\* and Noeline\*, for example, said that:

A man does get menopause...medical science doesn't recognise it but I am quite sure they do. Men have hormones as well. They get [male menopause]...when they go from being a good natured person to getting upset over things that wouldn't have upset them throughout married life...and then all of a sudden the odd little thing will niggle them that wouldn't have worried them once. So I often say, 'You are going through menopause, don't worry.'

I remember my husband saying to me once, 'Of course men go through the menopause'...and I said, 'Don't be daft'...and after that when he had his mood swings I used to understand... Things must change in their bodies you see. They do go through what we call the 'funny stage'...they don't know what they want to do and...they think their sex drive is dropping off!

I think they go through cycles of titchyness and depression...it's more than mid-life crisis, I think it is more physical...

I think some men go through a distinctive change as they grow older...my husband feels hot at different times... I suppose he just really has hot flushes too, he gets all overcome.

Similarly, Megan, wrote that she had a 'totally supportive husband' as he had 'suffered a two year male menopause a year ago and understands'. In response to my query as to

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<sup>10</sup> Flint (1982b:364) points out that the term 'male menopause' is a misnomer given the literal meaning of menopause as the final menstruation. Vermeulen (1997:334) notes that: 'In men, spermatogenesis and fertility are maintained until very old age and a sudden fall in sex hormones levels does not occur. Hence the male equivalent of the menopause, the andropause, does not exist. This does not imply, however, that the testicular function remains uninfluenced by the aging process, as both exocrine (i.e. spermatogenesis and fertility) as well as endocrine function decrease slowly but progressively with age'.

what the latter involved, Megan wrote back as follows:

My husband's experience:

1. What's happening to me, be there for me
2. Weight loss
3. Going out but not merrily. From a non-drinker to a regular (not offensive) drinker
4. Sighing over accounts, used to simply pay
5. Wanting to splurge money
6. Looking for other confidants
7. Feeling unloved
8. Anti the clan (?) (young adults)
9. Not coping
10. Health problems, diminished sexual performance

Two years to the day. Although I sensed a 'something that men go through' no-one said male menopause. He's the first to quote it now - calls it a cold flush... He's 101 per cent now, better than ever

11. Power - felt better organising things

Based on their personal observations of a range of behaviour and health changes affecting middle-aged and older men, the women were convinced of the existence of a male menopause. While acknowledging a lack of scientific recognition of male menopause, the women nevertheless agreed that it was a process of variable form and duration that could be attributed to hormonal causation of observed changes.

The women's use of the term 'male menopause' illustrates the hegemonic influence of a pathological view of menopause through their application of principles of female reproductive functioning to male behaviour. A pathological explanation allows an otherwise unaccountable change to be explained in terms of the activity of reproductive hormones. On the other hand, such an explanation may be a backlash to the assumption of female reproductive inferiority inherent in male jokes and 'put down' of mid-life women. In that case, the term signals a rejection of the notion of the 'universalised natural body' through neutralisation of the standard of the 'unmarked male'. In this way the notion of women as physiologically inferior and deviant is undermined. Either way, the explanations reflect a juxtaposition of common sense and medical knowledge which creates a quasi-syndrome to explain a loosely defined pattern of observed behaviour among men. This phenomenon is by no means unique to the New Zealand context as is evident, for example, in the *Readers Digest*, *Oxford Complete Wordfinder* entry of 'male menopause' as 'a

crisis of potency, confidence, etc., supposed to afflict men in middle life' (Tulloch, 1994:924).

The irony of the women's perception, of course, is that in attributing changes in their partners to a universal, biological mid-life syndrome they fail to take into account the impact of social forces - the very thing that women themselves have sought to have acknowledged in relation to their own experience. Perhaps the most striking example of this omission was Judy's\* description of her husband's behaviour change:

Well I know [male menopause was evident ] with my own husband [through] mood swings. I would say George changed [at about aged] fifty-five. He had been made redundant [as a clerk]...and he went to work at [a factory as a process worker]. I noticed a complete change to him, to the moods, to his attitudes, toward me. He would either have one awful mood or the complete opposite, do a complete circle. I noticed his behaviour changed [in] the way he would speak. He would speak [with] no respect. I actually wondered if it was some of the people he was working with. He's a lot better since he has retired and turned sixty. A man would deny it! A man would deny [that they go through male menopause] but I am sure they do!

Missing from Judy's\* explanation of her husband's behaviour is an explicit recognition of the impact of a forced occupational change, a factor she appears to have considered ('I actually wondered if it was some of the people he was working with') but rejected. It seems quite likely that George's behavioural change reflected his frustration over a dramatic change in circumstances that he was powerless to prevent. This point is also made by Flint (1982b:365) who argues that attributing menopausal symptoms to middle-aged and older American males overlooks the impact of social pressures such as age-related changes in status.

To sum up, it has been shown with regard to the loss of fertility as a central aspect of the meaning of menopause that the majority of the women in this study viewed the end of menstruation as a positive event (e.g. freedom from monthly hassles and discomfort and from the fear of pregnancy). This view and expectation provides a clear demonstration of the role of common sense knowledge derived from personal experience, observation of others and perhaps a tacit understanding between women. For a small group, however, the cessation of menses was viewed with ambivalence or sadness that reflected a desire for

more children and a sense of diminished femininity. Underlying the latter was the association of female attractiveness and sexuality with youth and fertility, a view manifest in the perception of menopause as a marker of ageing and a fear of becoming a 'dried up, wrinkled hag'. The point was also made that when viewed against the standard of youth and the 'unmarked male' the ageing female body appears doubly deviant. Finally, the women's use of the term 'male menopause' in relation to the behaviour of partners demonstrated the impact of the hegemonic view of menopause as a pathological event. It signalled also - through the promotion of the view of a universal, physiologically driven, mid-life syndrome - their rejection of the female body as being physiologically deviant.

### **HEALTH RISK**

In a review of attitudes towards menopause, Utian (1997) points to the negative images portrayed by Victorian literature which emphasised the loss of youth, beauty and health. The point is made that the comments of Borner, who in 1887 drew attention to the ill-defined boundary between normal physiology and pathology, still apply nearly one hundred years later. 'The narrow boundary... ha[s] not been fully defined... Nor ha[ve] the many negative and largely unsubstantiated statements ceased' (Utian, 1997:3). A recurrent theme throughout the present and previous chapters is the perception of menopause as a pathological state which signals the loss of youth and attractiveness in addition to physical decrepitude and decline. It is not surprising, therefore, if menopause is portrayed as a treacherous passage and as a health hazard of female mid-life.<sup>11</sup> For example, Wilson (1966:165), the original proponent of oestrogen replacement for menopausal women, commented on the 'decline of his gentle, almost angelic mother' at menopause:

I was appalled at the transformation of the vital, wonderful woman who had been the dynamic, focal point of our family into a pain-wracked, petulant invalid. I could feel the deep wounds her senseless rages inflicted on my father, myself and the younger children.

Similarly, in response to the presence of women congressmen in the United States legislature, Dr. Edgar Berman, personal physician of former Vice President Hubert Humphrey, is reported to have said (Fausto-Sterling, 1992:91):

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<sup>11</sup> See Martin (1987), Barbre (1993) and Coney (1993).

Even a congresswoman must defer to scientific truths...there just are physical and psychological inhibitions that limit a female's potential....I would still rather have a male John F. Kennedy make the Cuban missile crisis decisions than a female of the same age who could possibly be subject to the curious mental aberrations of that age group.

Approximately one third of the women interviewed for this study indicated that they had heard of or known women who had 'gone funny', 'done strange things' or been admitted to a psychiatric institution around the time of menopause. The remarks of Norma\*, Emily\*, Marie\* and Noeline\*, for example, reflect a perception of menopause as a time fraught with emotional difficulties:

I think women at a certain age are very emotional too. Women I think will put up with a lot and I think when you are going through menopause you are sort of fighting a losing battle until in the end, every so often, you get break points where it all comes out.

I have seen [other people] with menopause that do have these terrible depressions and they virtually seem to have a personality change...its only for maybe a couple of years.

Mum got very down. Dad used to get very concerned about her and would say odd things to me.

I have known people...who through the menopausal time...have had perhaps a nervous breakdown or anxiety attacks. They have had to have time out and be helped in those areas.

Despite the findings of prospective Northern Hemisphere studies that menopause 'is relatively unremarkable for most women', its association with depression and other emotional changes remain commonplace (Liao and Hunter, 1995:101). Avis and McKinlay (1991:77), for example, found that among a group of women from Massachusetts a 'high percentage...believed that women become depressed or irritable during the menopause but otherwise believe that menopause has little effect'. On the other side of the Atlantic, in a south London study, Liao and Hunter (1995:111) noted that a large proportion of women expected to experience problems during menopause, particularly those of an emotional nature. In New Zealand a report on the experience of women in mid-life produced by the Society for Research on Women (SROW) (1988:45-46) pointed out that:

...folklore suggested some people saw menopause as a 'bogey' - one of those crosses which women have to bear - in the same way that menstruation and childbirth have been viewed in our society in the past.

Despite such a suggestion, SROW (1988:46) reported that of those who participated in the survey, only 3 per cent expected severe problems, 42 per cent expected mild problems, 33 per cent anticipated no problems and 22 per cent indicated that they hadn't given the matter much thought. Finally, in another study of Canterbury women, Hamilton (1990:84) noted that concern about the risk of emotional instability and nervous breakdown, together with a fear of 'something vague, mysterious, terrible' dominated the negative perception of menopause held by 59 per cent of women interviewed.

The view of menopause as a positive, uneventful and natural life-stage dominated the perceptions of the women in the current study although a few did refer to the 'bogey' image identified above. In most cases, the 'bogey' perception could be attributed to childhood events and was associated with a sense of fear and dread which, although generally unfounded, nevertheless informed their stoic attitudes and behaviour. Marion\*, for example, reflected:

It was quite a big thing in my mind, built up by an aunt. I think the whole thing was negative... we would be out on a picnic somewhere. In those days big family picnics used to be held on New Year's Day and that sort of thing and she would be sitting on a rug and I can see it now, she would go puce, poor thing. She must have been going through hell... but that is what formed the bogey in my mind.

Contributing to the women's acknowledgement of menopause as normal, natural and uneventful was the ethic of stoicism identified earlier. Indeed, many of the women indicated an acceptance of menopausal symptoms as a 'fact of life'. From this perspective, hot flushes and to a lesser extent menstrual irregularities (particularly flooding) were considered 'normal' aspects of the menopausal transition, along with night sweats, memory loss, loss of libido, crawling skin and weight gain.

For some women, however, the expectation of both hot flushes and flooding as 'normal' was accompanied by a fear of embarrassment and lifestyle constraint.<sup>12</sup> Catherine\* and Judy\*, for example, both found the prospect of hot flushes daunting:

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<sup>12</sup> Hamilton's (1990:103) study found that 61 per cent of respondents felt menopause could be embarrassing, with 59 per cent identifying hot flushes as the cause of most embarrassment.

What worries me though [is hot flushes]. Well that [is because of] what my friend said to me. She said, 'Oh Cath this is so embarrassing because you know I can vacuum the floor and you must see the sweat. Oh it's terrible!'

I have seen women in the shops when they have gone red from [the chest] up. I hated the thought of that happening.

In the case of menstrual irregularities, a number pointed to tiredness and a general lack of well-being in addition to the social inconvenience and disruption associated with episodes of flooding. Emily\*, for example, had a number of friends who:

... are going through a bit of a build up... to menopause and they might be bleeding for three months. I was out with one of them yesterday and she had three changes of clothing within about four hours. It was just horrendous! She said she knew she shouldn't have come. I felt she was jolly brave to come, I mean she came armed with a suitcase of clothing!

Nora\* and Louise\* both held clear memories of their mothers' difficulties with severe flooding which in each case resulted in a hysterectomy. Louise\*, who was starting to experience menstrual difficulties, was concerned that she was going to follow the example of her mother:

Well the thought of having an operation absolutely horrifies me. I can't think of anything worse. I mean I think I would die, that's what I am scared of... having a cardiac arrest while I am under anaesthetic!

The prospect of a hysterectomy around the time of menopause was also raised by other women. Some, such as Jacky\* and Mary Ann\*, voiced strong opposition to surgical intervention for the relief of 'normal' symptoms, believing that 'nature' should be allowed to take its course. Others, like Louise\*, sought reassurance from friends that their own experience was in fact normal:

I mean I have talked to a lot of people who have [similar menstrual difficulties]... they have reached a stage in their lives too where they actually have to think twice about going anywhere on the day they get their period.

On the other hand, several of the women acknowledged that a hysterectomy had markedly improved their quality of life. One of these women was Colleen\*, who said:

I had a prolapsed bowel and bladder... [and]... lots of urinary tract infections and when I was taking HRT (the progesterone tablet) I always felt yucky on that. Oh yes, it was wonderful [to have all those problems fixed].

## HRT

Compounding the women's understanding of menopause as a health risk was the promotion of the deficiency disease perspective. As an oestrogen deficient state, menopause is viewed by some health professionals as a *permanent, pathological* condition which affects mid-life and older women and so requires treatment if the risk of heart disease and osteoporosis is to be avoided.<sup>13</sup>

In response to the deficiency disease model the women displayed a range of expectations and perceptions about the risks and benefits of HRT. The narrative of Sue N (one of the eight at the beginning of this chapter) for example, indicates her awareness of medically identified, long-term health risks associated with menopause. Her comments, however, also reveal a self-perceived low risk of coronary heart disease. She was confident that menopause did not present a threat to her health and therefore saw little or no good purpose for the use of HRT in terms of the benefits it would produce. In contrast with Sue N, both Barbara\* and Sue P were assured of the ability of HRT to reduce their risk of heart and bone disease after the onset of menopause:

The doctor told me at my last check-up [that] he thinks I will do well on HRT and he wants me to have that because they have discovered that it would be good for the arteries, and yes, I will give it a go.

I believe that HRT is very important. There are a few women who feel that HRT is something that male doctors try to force onto female patients in some show of male dominance. To that I say, 'Garbage'! You are merely replacing something which your body is no longer able to supply and the fact that it relieves so many symptoms - plus keeping bones and hearts stronger - must be in its favour.

Others, such as Emily\*, pointed to the transformation they had witnessed among friends who had gone on HRT. They therefore indicated a willingness to try such treatment should the need arise. As Emily\* put it:

I know one of the girls on hormone patches is just back to her old self, she is just brilliant. But the other one I am thinking about, she is always rather tired and worn out but says 'I want to do this naturally, not have any extra help', which is fine. That's her choice but I mean, to me, personally I will be taking any help I can get if it makes it simple or easier or whatsoever, bar a hysterectomy!

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<sup>13</sup> See the comments of the specialist consultants in Chapter 3, in particular those of Professor Barry Wren.

Emily's\* comments indicate her personal observation that HRT treatment can bring back your 'old self'; by implication, HRT offers effective psychological as well as physical benefits to women at menopause.

Several women were adamant that HRT was 'the best thing since sliced bread'. Judy\*, for example, labelled it a 'miracle pill'. Not only did she 'feel so well' while on the therapy but she attributed to HRT the youthfulness and fitness she observed among a number of older women:

It is good to know that we can be helped because I think back twenty, thirty or forty years. Those poor women, they aged so quickly and they didn't have this help that we have... You see from what I have read, women seemed to get older quicker, they came to a standstill. They couldn't do things that they [used to be able to do...but] if they have HRT they [can] do things. I just think it is wonderful, I really do.

Trisha\* pointed out that HRT preserves both a youthful appearance and a woman's bones:

Some books I have read...have declared that it is the miracle drug. I think Gail Sheehy was really in favour of it and I have friends who are on the patches and they are just wonderful. They are energetic and youthful looking and it seems to restore their skin and everything. They say in a lot of research that they have done in America that it stops osteoporosis.

Dulcie (aged 78), on the other hand, who had found menopause a very difficult time, remarked 'I grieved for the fact that I was not offered HRT by any of my doctors'.

Although very positive about the benefits of HRT for the relief of their own menopausal symptoms, Shona, Marilyn and Moira were nevertheless aware of possible risks associated with the treatment:

I think it is wonderful for me [but] I cannot speak for everyone. I do feel that women should be given all the facts and be allowed to make their own informed choice. After all it is their body and they have the right to protect what is theirs.

I know for me that I couldn't have got by without it. I am fortunate in a way. I have had a hysterectomy so there is not the danger of cancer of the cervix.

I endorse HRT as long as vital signs are stable and [there are no other] risk factors. I also tried alternatives but they weren't very effective.

However, although a number recognised HRT provided a welcome relief for unpleasant, short-term symptoms, it was clear that most remained unconvinced of the overall merits of

the therapy. Helen\*, for example, pointed out the resumption of menses outweighed any possible benefits associated with taking HRT:

I had a sister-in-law who went onto HRT...and she got her period back. At the time...all this about osteoporosis had come out and I thought perhaps I should investigate [HRT] because...being small boned and fair and light [I am at risk] and then I thought, 'Oh, you have to get your period back!'

Moreover, strong reservations about the safety of long-term use of the drug were also expressed. Helen\* and Beth\* mentioned that some women felt frightened to go on HRT, while Anna\* was bothered that it may cause blood clotting as a woman gets older. Others, such as Bobbie\*, commented 'hormones are very dicey' and questioned the possibility of undocumented side-effects. Particular concern was expressed over the risk of breast cancer, especially among women considered at high risk from this disease. Joyce\* was a case in point:

I did have HRT tablets for a while but I tried to do without them [because] I have heard a whisper that they could be cancer causing and I am a high risk person anyway. My mother and my Dad's two sisters all had breast cancer. I was [worried about it].

Zelda, who had had a bilateral mastectomy, had been advised by her specialist not to take HRT. She pointed to the lack of publicity and information about the risk of breast cancer for women such as herself. The difficulty of access to 'objective information' about the risks and benefits of HRT was also noted by others.

A problem of another kind arose in the face of information on *both* the risks and benefits associated with the use of HRT. Attracted by the benefits, some of the women felt confused when they discovered or became aware of the risks. Pat, for example, who had a family history of heart disease, had been concerned:

I'd lose my 'natural protection' when I reached menopause and was thus attracted to HRT if it could restore oestrogen levels and help protect me against heart disease...But I've been rather confused as well as it appears that HRT is not recommended if a woman has existing heart disease or high blood pressure. I was a bit doubtful about the increased risk of breast cancer and at the same time attracted by the possibility of protection against heart disease.

Pamela also indicated confusion about taking HRT:

I sometimes wonder at the logic of it all when if you take HRT you help your bones and protect your heart a bit but run the risk of cancer. So if you don't take HRT your bones will suffer later on in life and you could have heart troubles etc.

Pat and Pamela were, in fact, part of a small group of women who were reluctantly taking HRT as a last resort to overcome unpleasant menopausal symptoms.

One characteristic of reservations associated with the use of HRT was an unwillingness to put an 'unnatural' substance into the body. Anne B\*, Jackie\* and Marie explained:

Well I would certainly hesitate before using [HRT] but then its like pain relief when you are having a child...I would prefer not to [have to take HRT] having read a little about [it] because I see [menopause] as a natural process that you go through and...with my experience of the contraceptive pill and taking artificial hormones, my body doesn't like them.

The doctor was always on about HRT, but I had read a lot of stuff about that and I was very reluctant to take anything that was artificial because menopause is natural, puberty is natural...Why should you need something artificial?

Now that I have found homeopathy I wouldn't touch HRT! There are no side-effects, [its] non-invasive, no pills to take. Better quality of life than before because HRT does not address or enhance your life all round.

These views appear to be similar to those that O'Leary Cobb (1994:526) refers to in relation to 'a handful of [Canadian] women who refuse HRT simply because they do not want to put 'chemicals into their bodies''. One suspects that in New Zealand these women are part of a much larger group that prefers to use 'natural' remedies (see Chapter 8) and who probably have much in common with a similar group in Canada who 'regard it as common sense to look first to gentler remedies' (O'Leary Cobb, 1994:529).

At issue here is the control of women's bodies through medication, medicalisation and commodification. For example, Jackie's\* concern about the use of HRT clearly extended into the political arena. She made the link between the promotion of HRT and the process of medicalisation, pointed out that childbirth had been medicalised and taken away from women, and asserted that the same thing was now being done with menopause as a money making business. Anne B\* was concerned about the type of publicity in popular women's magazines. Referring to such a magazine that she had read 'in a doctor's waiting room or somewhere', Anne B\* identified an article in which Prince Charles was reported to have insisted that Mrs. Parker-Bowles go on HRT. Reflecting on this item, Anne B\* remarked:

So yes, there is one attitude. HRT is the panacea for all these menopausal complaints and...what bothers me about it is that [after the publicity of Mrs. Parker-Bowles] women [will] just run off and take it, unaware of the risks!

Others felt that the promotion of HRT capitalised on a woman's desire to remain 'young and beautiful'. In the narratives of Mary Ann\* and Nora\*, for instance, reference is made to HRT as 'the fountain of youth stuff' and 'the big hype... [if] you want to be young and youthful...get HRT'. The point to be made is that each of these women sensed or was aware of the link between the promotion of HRT and the social perception of menopause as a sign of ageing, the loss of youthful attractiveness, sexuality and fertility - all of which are integral to normative definitions of the feminine.

To sum up, three views towards HRT were identified among the women in this study, each demonstrating the salience of common sense knowledge derived from various sources (including the deficiency disease model) but tempered by agency in relation to personal circumstances. The first involved a minority who regarded HRT as a wonder drug and were unconcerned about possible side-effects or associated risks. The second view was expressed by those who, although taking HRT, were concerned about possible long-term side-effects (e.g. Shona, Marilyn and Moira). For this group, however, any doubts about the safety of HRT were outweighed by its effectiveness in alleviating their unpleasant symptoms. The third view (accounting for the largest group of women) was expressed by those who were generally opposed to taking HRT because of concerns over possible side-effects, particularly the risk of breast cancer.<sup>14</sup> Moreover, a number of these women indicated an unwillingness to put anything 'unnatural' into their bodies. Overall, the dominant view was one of a desire to proceed through menopause 'naturally', although some of the younger women, such as Anne B\*, recognised that their views might change if they encountered severe menopausal symptoms.

### **Health Problems at Menopause**

Finally, a number of the Feilding-Manawatu participants and *NZWD* respondents pointed

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<sup>14</sup> See Coney (1993).

out the danger of attributing all mid-life health problems to menopause. Some, like Helen\*, referred to the earlier, commonplace practice of treating a wide range of health problems reported by mid-life women with tranquillisers:

Well my mother always said that she had very bad flushes and of course in her day whatever you went [to the doctor with] you got tranquillisers, even [for the] 'change of life'! ...it didn't matter what was wrong with them, it was put down to being menopausal. They weren't allowed to have any other symptoms or anything else wrong with them.

In Judy's\* case, the more recent death of a friend had alerted her to the danger of attributing all mid-life health problems to menopause:

...they blame every thing on menopause... a very dear friend of mine - she and I were going through the crawly [skin] business at the same time... came to me and said 'Look at my stomach' and she had quite a big tummy. I said, 'Have you been to the doctor' [to which she replied that the doctor had responded] 'Oh its just 'the change', menopause, don't worry'. They happened to leave Feilding... and the next thing we heard was that she had been rushed to hospital. She had a massive cyst and her uterus actually burst and it was full of cancer or whatever and she ended up dying. This lady wasn't yet fifty! That's why I feel so adamant about it...it has to be proven that it is menopause before they put a label on it.

The acknowledgement of menopause as a time of health risk highlights a number of themes identified throughout this chapter. Underlying the themes are stereotypical notions of menopause as a treacherous passage of hormonally driven physical and mental decline, signalling a loss of youth, fertility and attractiveness, and the onset of old age. Contributing to the women's perceptions is the deficiency disease model which is endorsed through the promotion of HRT to reduce the risk of long-term symptoms, such as heart disease and osteoporosis. Overriding the HRT promotion, however, was the dominant view among the women of menopause as a normal, natural event involving a range of symptoms such as hot flushes and emotional disturbances. Indeed, taking a broader view, it may be said that the concerns expressed about the safety of HRT and its rejection as the elixir of youth, together with the ethic of stoicism, further indicates the importance placed by the women on the life-stage perception of menopause. That said, the women's views and expectations nevertheless exemplify the often contradictory and disjointed character of common sense knowledge.

## CONCLUSION

In this chapter the themes of mid-life and ageing, loss of fertility, and health risk provided the framework for the examination of attitudes, perceptions, expectations and meanings associated with menopause. The women's recognition of menopause as a normal, natural life-stage signalled the ability of the body politic to regulate and constrain individual perception and experience, in this case through the notions of social and physiological deviance. Their perception of menopause and expectation of stoic acceptance and endurance of symptoms, exemplifies a social situation where to share the experience in certain contexts and by certain means is to invite judgement and sanction. In contrast, scientific identification of the 'unmarked male' as the 'universalised natural body' classifies the female body and its reproductive functioning as physiologically deviant. However, while very few of the women contested the social requirement of stoicism, most insisted on the normality of menopause and many also pointed to the existence of a male equivalent ('male menopause') which further challenged the notion of the female body as physiologically deviant.

Associated with the view of menopause as a normal, natural life-stage was its recognition as a process that was a part of mid-life and ageing. For some women this meant that menopause was the beginning of decrepitude and decline while for others it represented freedom from menstruation and the insecurities of youth, diminished family responsibilities and new opportunities. A view of menopause as 'liberating' was common among the older women, such as Marion\*, who attributed their good state of health and enjoyment of life to the absence of both menstruation and a fear of pregnancy. There was also, however, a tension between the perception of menopause as a time of freedom and as a marker of ageing. This tension was particularly well illustrated by Jill's\* comment that the onset of menopause is initially a time of loss and grief which is followed by the realisation that 'life still goes on and things come brilliant again'.

Jill's\* comments highlight the complex, dynamic, context-dependent nature of meanings attached to menopause and the tensions generated from the diverse range of personal and

social experiences. The loss of fertility at menopause illustrates her point. As a central aspect of the meaning of menopause, the end of menstruation was viewed by the majority of the women as a liberation from the hassle, discomfort and expense of monthly periods. Among older women, in particular, it also meant a release from the fear of pregnancy. In contrast, a small group associated menopause with loss and sadness. For them it signalled the end to childbearing and even a diminished sense of femininity. The point is, that as an event marking the end of fertility, which is popularly perceived as the 'essence' of what it means to be a woman, menopause signifies both liberation and loss. Moreover, in the context of a youth orientated culture which associates sexuality with attractiveness, it was not surprising that a number of the women perceived menopause as a marker of ageing and were fearful of becoming 'dried up, old hags'.

Finally, the view of menopause as a health risk was associated with childhood impressions of this event as a 'bogey' and more latterly its medical promotion as a deficiency disease. A number of the women voiced certain fears based on observations which in many instances could not be substantiated. Such fears appear to reflect the nature of the negative stereotypes which are part of the common sense understandings and the remnants of the taboo which have surrounded this event. Although the limitations of common sense knowledge have provided the opportunity for the domination of the deficiency disease view, the majority of the women nevertheless indicated their rejection of this perspective. Indeed, there was an unwillingness on the part of many to put 'unnatural' substances into their bodies, while others expressed concern over the possible side-effects associated with HRT.

The women's rejection of 'unnatural substances' reflects a complex set of factors. On the one hand, it buys into the essentialist notion of 'natural women' undergoing 'natural' biological processes and so rejects the artificiality of employing 'unnatural' mechanisms of symptom control. On the other hand, the seeking of 'natural' remedies signals both compliance and resistance to the idea that menopause, as a natural life-stage, can or should be 'treated'. It overlooks, for example, the fact that the very act of stoic endurance

is itself a 'natural' strategy of symptom relief while at the same time conveying resistance in the form of personal independence and control. Among a small group, however, the need for symptom relief outweighed any misgivings they had about treatment with HRT. Several of the women were adamant about the benefits of HRT, and one commented it was 'the best thing since sliced bread'.

Overall, the themes and views presented in this chapter appear to apply with remarkable uniformity to both groups of women involved in the study - that is, participants from the Feilding-Manawatu district and the *New Zealand Woman's Day* respondents resident throughout New Zealand. In general, the women's perceptions, attitudes and expectations towards menopause reflect complex and constantly shifting relationships between personal and social desires and experiences. Viewed against the standard of youth, 'universalised natural body' and the notion of 'natural' the women's rejection of the menopausal body as physiologically deviant illustrates their ability to exercise a range of perceptions, attitudes and expectations commensurate with their experience. In other words, the standard of youth, 'universalised natural body' and notion of 'natural' merely project a set of culturally specific assumptions, contradictions and meanings underpinning common sense knowledge about the female body and its reproductive functioning at mid-life. Viewed in this way, it was not surprising that the women in the study confirmed mid-life and ageing, loss of fertility and health risk as themes central to the meaning of menopause.

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## Chapter 7

### Our Stories

#### The Menopause Narratives of Fourteen Women.

In the two previous chapters, information obtained from all of the participants aged thirty and above has been used to explore aspects of the women's knowledge, attitudes, expectations, perceptions and meanings of menopause. These two chapters provide the necessary background against which the experience of menopause can be examined. Accordingly, the focus of the investigation now becomes somewhat narrower as it *excludes* those participants who had *not yet experienced* the onset of menopause.

Chapter 7 now presents an in-depth account of the *experiences* of sixteen of the fifty-two women in the study who defined themselves as 'in' or 'through' menopause. The women's narratives are edited versions of either interview transcripts or written responses and have been selected as representative of the range of experiences of others of a similar age. An effort has also been made to include a balance of participants from the Feilding-Manawatu District and *New Zealand Woman's Day* respondents. Although some of the material included in these narratives has previously been cited (in Chapters 5 and 6) it will now be employed for the purpose of examining the experience of menopause. Beginning with the oldest respondent and moving through to one of the youngest women, these sixteen narratives provide an overview of the experience of menopause across four age groups of New Zealand women; that is, women seventy and over, and those in their sixties, fifties and forties, respectively.

The chapter has two key objectives: first, to establish a starting point from which to examine and discuss the *experience of menopause* in Chapter 8; and second, to offer a holistic view of menopause. The latter objective is of particular significance here as it is intended to counter the unavoidable fragmentation that occurs when selected aspects of experience, required for data analysis, are extracted from the narratives of participants and respondents.

### **Mary\***

*Aged 81, Mary\* was the oldest respondent in the study. She has lived most of her life in the Feilding-Manawatu district where she grew up and farmed with her husband. She has been widowed for twelve years and has two daughters and a sister still living. Mary\* was the only member of the Feilding Women's Division of Federated Farmers, to respond to my letter requesting respondents for the study. She had been a member of that organisation for over fifty years and explained that it had an ageing membership and was likely wind up at the next Annual General Meeting. She was perplexed by the negative attitudes of her fellow WDFFF members to my request for involvement and stressed that she couldn't understand 'their unhelpful attitude'. Mary's\* comments are drawn from my notes as the tape-recorder malfunctioned during the interview.*

Mary\* did not remember much about menopause as she was 'too busy working on the farm at the time'. She had felt no need to 'read up' on menopause and admitted 'it just happened' and that she 'hardly noticed it'. She remembered that her periods became more and more spaced out and finally stopped when she was forty-eight years old. She thought she may have experienced 'the odd hot flush'. Mary\* commented that 'women didn't really talk about such things, they just got on with it'. As a result she had no knowledge of other women in the area going through menopause or experiencing problems. 'Women kept such things to themselves and were too busy getting on with their lives'.

Mary\* 'didn't really talk about' menopause with her mother although she was happy to discuss it with her daughter who at the time of the interview was experiencing menopause-related problems. Looking back, Mary\* felt that the passage through menopause was a 'non event' in her life.

### **Dulcie**

*Aged 78, Dulcie is a New Zealand Woman's Day respondent and retired teacher from Rotorua. Her former husband was an engineer. She wrote, 'I'm very interested in your research into menopause, as I believe that there is still in this supposedly enlightened age, not enough support available to help women in need of much understanding during this very difficult period.'*

The time I began menopause was when I was about fifty years of age. I had my usual period and then no more for six months when I had another usual period which proved to be the last. [I experienced] hot flushes [which] lasted for about two years and then I

had a break of approximately two years [before] they recommenced and lasted for about sixteen years, by which time I was almost suicidal. [A]fter telling this to the doctor he arranged a referral to a specialist gynaecologist and in time the hot flushes stopped through medication. During this continuation of hot flushes I numbered among the doctors I was attending two women practitioners [but] none of the doctors suggested hormone replacement. At this time I used to read and hear about the fact that women these days need not suffer bad effects from menopause. I grieved for the fact that I was not offered HRT by any of my doctors, but then later, when I learned that this could cause heart trouble at a later date [sic], I felt that perhaps it was just as well that I hadn't undergone it.

I had the added trouble of an under-active thyroid and also a husband who didn't understand women, let alone a menopausal woman, and so I suffered very great trauma in this direction. I feel very strongly that not only women should be taught of the possible effects of menopause on them but [their] husbands also, as an understanding husband could be of immeasurable help and comfort to a wife in this difficult period of her life.

Having belonged to many groups where women went together, and [having visited and been] visited by many women I have found that they never, ever discuss the subject of menopause and I myself have never brought it up, except on the occasions when someone noticed that I was still having hot flushes, but the subject was never elaborated on. My mother was very diffident about talking about such topics as menopause and she had died when I reached that stage.

When I was young I used to wonder why so many women, old as I used to think then, but probably only about fifty years old, were so crotchety. But now, at this advanced age, I realise that this irritability was no doubt due to their menopausal age. I feel very much that people in general should realise that this bad [temper] is entirely out of their control and yet people judge them, usually permanently, on their crotchetyness at that time.

Because of my added trauma at the time of my menopause, I look back on it with great sorrow and I feel that anything that can be carried out to prepare women for this eventuality (and the educating of husbands as to what to expect psychologically as well as physically) should be undertaken at all costs.

### **Beth\***

*Aged 71, Beth\* is a focus group and in-depth interview participant who has lived in the Feilding-Manawatu district nearly all her life. The mother of two daughters, she and her husband are both retired. Beth\* is an active member of her church, Victims' Support and the Feilding Patchwork Quilters Club. Much liked and respected, she was identified by other women in the study as a person they could go to and talk over their problems. At the time of the interview she had been on anti-depressants for four months and appeared rather 'flat' and close to tears at times. Afterwards, Beth\* admitted that she had been worried she would get tearful during the interview but had found it helpful to talk about her problems. She also indicated that she felt trapped by her life circumstances and isolated in terms of intimate contact with others, including her husband. Her community involvement was a deliberate strategy to overcome some of her personal difficulties.*

Well I was a bit of late starter. I was fifty-six when I had my last period but I had all sorts of symptoms before [then, such as]...lack of concentration and tiredness, and flushes and irritability. [You] see I got depression...my bladder went...and everybody else seemed to be fine, [they were] sailing through it. Their periods stopped and nothing else happened. I seemed to have everything. I had to have a curette before my bleeding stopped and I had bladder problems. That's when I went on to HRT. My well-being improved markedly on [HRT].

In 1969 my husband went out of business. He [had] started off as a builder on his own [and was] a good tradesman but no businessman and things just went downhill over the years and there was never any money. So the final crunch came and I was very lucky to get [a] job because we decided that we really should pay [all the debts] off rather than go bankrupt. So I went to work in 1969...as a bookshop assistant. I would have been about forty-five [years old]. My mother died about the same time. She and I had been really close. That was hard and I worked for just on twelve years but it took us five years to pay off the debt and it was my money that paid it off really.

We brought up our two girls in that time and I think that I just got totally burnt out towards the end of it... I really just about had a nervous breakdown I think. It would have been all right [if, until] my eldest daughter got married and the younger one had gone off to Massey [University], I could have had somebody at home doing the housework... but it all got too much and the garden got really messy and my husband is not one that you can really talk [to] about how you feel. You know, he just doesn't understand. He doesn't really try to understand if I am honest. He says, 'Oh don't worry about it, let it go'. So I think at the end I really got burned out.

The first time I can remember having a very bad [hot flush] I was at a meeting at the church hall. I was standing having a cup of tea talking to someone and all of a sudden I got this terrible, you know, head to foot thing, and I thought, 'Oh I am ill. I am going to faint!' I had to think about what it was at the time and I really felt terrible, and when they started coming regularly I thought that was what they were all right. I used to get embarrassed because I used to go all red! Oh I am sure [other people noticed]. Sometimes I'd get quite a lot of perspiration on the forehead. I used to feel yuk. You know, they would seem to have to sort of drain out... they seemed to take their time. Oh yes [I had night sweats]. I used to throw the blankets off all the time. I think they must of woken me and I would wait until I was really cold (whether it was winter or what[ever]) before I put the blankets back. I think it is sort of weakening too.

I went to Dr. B who was our doctor at the time and as we talked he said, 'Oh I think you need some help. I think you are really depressed'. And he asked me a few questions and then he put me onto an anti-depressant which was absolutely wonderful and he said, 'I think you have been called upon to do things that you really shouldn't have had to'. He was [very understanding] and it was strange because after we had been talking he said, 'Well once I would have said to you the menopause is something that all women have to go through, it will take it's course and you will be all right. But recently I attended a conference where they talked about these sorts of things and there were two men there [who] said why should a woman have to suffer these menopausal symptoms when she really doesn't need to?' [As a result of this conversation the doctor also put her on HRT].

After I had been on [HRT] for a while I said to [the doctor] 'If only I'd come to you eighteen months ago I would have been a different person'. But you didn't talk about that sort of thing...you were supposed to be able to cope. I think I said before that [my mother]...didn't really talk about these things. [Menopause]...was just something that 'you had to get on with'. You just put up with everything and you didn't tell anybody. I do [think it makes it much harder]. I can't see any harm in talking to your doctor about [menopause] and saying is there anything that can be done. Why should you be miserable all the time? Nobody understands how you feel because you don't talk about it and you get ostracised in a way because 'She is in one of her moods!'. Oh well, there may not be [that sort of feeling] now, but there used to be. Yes, [if] you can't put up with it, you have got no backbone. I spoke to a woman when I had just started, I suppose, and she hadn't had any symptoms at all and she couldn't understand why I was making such a lot of how I was feeling.

Just a few years ago they talked about the fact that if you were on HRT for too long it wasn't very good. You should have a bleed every now and then because of the build up in case of cancer of the uterus. So the doctor changed [the drug] and I had the most horrendous bleeds. I just bled and bled. Oh I couldn't go back to that! I had worse periods than I had when I was having normal ones! [The doctor] persevered. He even rang a woman up at Palmerston [North] hospital to discuss it with her. But gosh I use to flood! One [bleed] lasted for twenty-one days and I got a bladder infection because I had pads and stuff on too long. It was terrible.

I tried [the new pills] for about three months and then I said [to the doctor], 'This is not working...I'm sorry, I am not keeping up with this', and I really think he thought I was making a fuss. But I said to him, 'You don't have to deal with it!' So I went off [HRT] for a while, but now I am on a tablet called Kilogest which you don't have to bleed with at all. It's a combination [pill] and...you take it the whole time. I feel better on that. I must have been [on Kilogest for] about three years [now] and the doctor...talked about the fact that women when they get to my age might be more likely to have breast cancer and...said, 'Oh well, I think we will look at it in five years'. I will be about seventy-three [when] we will look at it again. I don't know what's going to happen when I go off it. What's going to happen to the bladder because I really need it for my bladder otherwise its this getting up in

the night and dribbling business and coughing [incontinence] and all that. I was [also] having hot flushes even a year ago [and] before I went onto [Kilogest]. The doctor said to me, 'Some women have no problems at all, some have a few but it looks like you have got the lot! It's the sort of thing that happens to some people. There's no knowing how its going to be.'

Because of the side-effects with HRT I have sore breasts all the time...a discomfort, not madly sore, but I am conscious [of it] if I knock [my breasts] or anything. It can get a bit uncomfortable but funnily enough the last couple of months it [hasn't been] happening. It's wonderful because it used to worry me. I used to think there was something the matter with my breasts. It's horrible because...as you get older your breasts get floppier and heavier and I am not a very big person but I have got quite a heavy bosom. I have got to have something to support it or it feels uncomfortable but [the tenderness] has improved just over the last few months.

I think [my husband] thought that I was going completely round the bend but I didn't care...I had to have some help. If ever I got uptight about something my husband would say its because of, 'You know, you are going through 'the change''. It made me angry because he didn't ever look for anything else. I mean you didn't get the chance to say perhaps what [the problem] really was. Well he knew that I was certainly not myself because I was depressed and I didn't sleep very well and I had all these hot flushes and I couldn't concentrate...he just put it down to 'the change' and that was it. I would be a bit down in the dumps...and often [menopause] would have nothing to do with it. If he had only said 'What's the trouble', or whatever. Yes, just sweep it under the carpet, everything comes under 'the time of your life', so you don't have to worry about [other causes]. I think I had a lot of tension in my life you see, financial stuff and that...it was hard sometimes. I don't wonder that I am back on anti-depressants because I think [it is due to]...about thirty years of pushing myself (we have been married for forty-five years) and probably more than thirty years of always having to be the strong one.

[Menopause is] a rather uncomfortable time for a lot of women. There are different things happening to you. When I was sort of feeling not so good I read a book on [menopause]. I got one from where I worked so I knew that I wasn't unique. I knew that these things were

to be expected in the menopause by some women...it was [reassuring] but at the same time I thought, 'I still have to put up with all the discomfort and the symptoms and the things'. You couldn't sort of be free and feel well. It was wonderful to get rid of the periods. I used to get migraine every month with my period, and that was one [good] thing about the menopause [the migraines] got considerably less and now if I get one it is very rare.

I feel safe with [my doctor] because he understands. You can talk to him and he doesn't make you feel as though you are just neurotic...he does his best to help you if he possibly can. I can ask him anything. I ask him anything because I made up my mind a few years back...it's my body [and] I might as well know what is going to happen if I take this pill. I want to know what is happening because if possible I want to enjoy the last days of my life. I don't know how many years I have got [but] I want to be able to enjoy [life and] what I can do.

### **Marion\***

*Aged 65, Marion\* is a focus group and in-depth interview participant. A retired farmer and mother of four children she has lived all her life in the Feilding-Manawatu district. She and her husband continue to reside on their farm and one of their sons farms on an adjoining property. Marion\* is an active member of the local rural community and Country Women's Institute through which she organised the participants for a focus group, held at the local school.*

I thought [menopause] had been built up into a bit of a 'bogey' by other people talking about it. Everything...that was adverse was blamed on [the] change of life. It was quite a big thing in my mind, built up like that by an aunt. We would be out on a picnic somewhere. In those days big family picnics used to be held on New Year's day or [similar] sort of thing and there she would be sitting on a rug...and suddenly she would go puce, poor thing. She must have been going through hell...and she would say, 'Oh it's menopause, change of life'. And I didn't have any idea of what she was talking about. She was my mother's sister-in-law...I think [the family] used to laugh it off really. That is what formed the 'bogey' in my mind, seeing that.

[Menopause]...wasn't [talked about in public]. It was something that was mentioned quietly, just whispered to, 'She's having a mid-life crisis'. It wasn't a thing my mother talked about a lot though because I don't believe she had any problem with it. She was so

reserved about things like that, so you see she didn't talk about menopause... and I doubt if she would have [talked] to her mother. That was the way she had been brought up. She didn't connect [her problems] with 'the change of life'. She used to get heart irregularities, palpitations and it always seemed to affect her in the middle of the night. She would have been about forty-five [years old].

[I have talked about these things with my sisters]...yes, absolutely, [there are] no barriers there. What's more we have talked about it to Mum since and she would say, 'Oh don't be silly. It's a lot of nonsense, get on with life. It's just a stage of living. Buck up!' One of [my sisters] has always been a plague to all these problems. She loves it all. I get really quite sarcastic about it. No one ever suffers as much as she suffers! Even the nieces of the family just make dry comments.

I don't think [menopause] ever was [discussed among women in the district about the same age as myself]. At the [Country] Women's Institute we have got the three of us in our age group and the rest are all young. One insists that she never had any problems with anything like that. Well her life is such a big problem I am sure she just doesn't want to admit it. There is [another] one [with whom] I wouldn't ever talk about that sort of thing...[but] I talk quite freely with the younger ones [rather] than the ones [of] my own age. [The women of my age] are all like me...too busy doing other things. I don't think [menopause] has ever been a problem in their lives really. You can see they are having hot flushes and that sort of thing and if the subject ever comes up we just laugh about it. You don't let it rule your life. I suppose we don't want to make it a 'bogey' for the younger ones.

I probably had quite a good knowledge of [menopause] because as a girl I went to Feilding Agricultural High School. I don't know whether you ever knew anything about its early years. We had a very innovative go-ahead headmaster, he had encouraged [the introduction of particular subjects so] that the girls should have [the information and knowledge required]....I suppose it was a branch of biology but it was called child psychology. That was a very broad term for the subjects it covered and one of them was the human body and its workings from birth to death and [menopause] was covered in that...so we knew that there was just a natural progression of the human reproductive system and that in women

the hormones and things just naturally stopped working. Probably, in a general sort of way, [menopause] would [occur between] one's forties [and] fifties.

I had a tubal ligation when I was...thirty-five. I couldn't take the pill and we didn't want any more children, having [already] had four. I had the thing done [but] no-one warned me that flooding was an offshoot from that...I used to have to buy disposable nappies...the large, all night versions....it got really bad just before the cessation really....every month for two or three days. I [felt really tired at that time] yes, [and] you did [have to plan your life around it], absolutely. But there you are, you put it into the back of your of mind and get through it. I like doing things...lots of people coming through [the household and] I like to go out and help on the farm. Well I don't now but I did then. I have always been involved with community affairs and so life was pretty busy and that sort of thing had to be coped with. It's amazing what you can get when you go looking, incontinence pants and that sort of thing. The chemist store was very helpful. It wasn't easy.

I have got a very hazy memory of it all as a matter of fact. It's hot flushes really...oh yes [and] skin irritation. I knew what [the skin irritation] was, it used to annoy me more than anything else. I used to get quite angry. [It occurred] mostly at night after a shower. It didn't last long, but the hot flushes, a sudden feeling of a great whirl inside you, that can still occur. Mostly it happens in the middle of the night in bed. You are asleep and all of a sudden you are awake in a lather of perspiration [and] you suddenly just want to throw all your clothes off...you don't want anyone in the bed with you...[my husband] generally went into his office...he [was] very sympathetic. He remembers his mother would suddenly get up and fling open the windows and throw off her cardigan and that sort of thing. He knew that it was something going on in [my] body.

I know what causes [hot flushes] so I just try [to avoid] too much tea and coffee, and bananas. I have to eat bananas because I have got a vascular problem and...at least one banana every morning is part of the antidote for the side-effects from the diuretic. I have the banana at breakfast with some cereal and I suppose within the first hour anyway I suddenly get this...it is quite a clammy feeling. [It is not very pleasant] but when you know what has caused it then you know that...it's not going to occur again during the day. That's it! [It lasts for a couple of minutes and] you get busy and do something to take your mind off it.

[Menopause] seemed never ending at the time...I didn't measure it but [it went on for] a couple of years, I would say for three years. When I got my last [period I was] forty-seven. I went quite a long time without a period and then, whether it was excitement or what it was [I don't know, but] I was attending my son's graduation and I got a period that day. Oh I nearly died! I thought that was a cruel act of fate. I felt ghastly.

I do think some women get off very lightly, [menopause] doesn't obviously disrupt their body. Why it should be so difficult for others I don't know [but] some women suffer drastically from it and I suppose a lot is mental attitude. But I do think that Maori and perhaps all native women handle it much more easily than European women because they don't seem to have any thoughts about it. It is like it is something that is endured. I think, to be quite honest...there is too much talk about this sort of thing always. I listen to Kim Hill [on National Radio] sometimes and think, 'Oh what a lot of blabber. Why not just get on with life, do something else. Let your bodily symptoms fade into the background'.

I do [think life is easier now]. Oh yes [menopause is a positive thing], it's good. I didn't think it was anywhere near the thing it was made out to be. Yes it wasn't too bad. I don't feel as if I am turning [into] a wizened heap. So I think [that] the ones that must have suffered very much [are the women] that seem to dry up. I think I have been healthier and stronger since [going through menopause].

### **Helen\***

*Aged 62, Helen\* is a focus group participant who had spent much of her adult life in Hawkes Bay. The mother of two daughters and now separated from her husband, Helen\* had moved to the Feilding-Manawatu district and become involved in community groups. She met Beth\* through Victim's Support and they had become firm friends. It was through Beth\* that Helen\* became involved in the study.*

I think I was forty-five [when menopause started]. Well I don't know, I might have been one of the lucky ones...because mine just started off that I just missed [a period for] a couple of months and next year [at] the same time I'd missed those two months and another one. It was one month and [then] two months [and] three months in three years and then it was all gone. I had flushes during the day. I would get a bit uptight. I was working full-time which I thought really helped me immensely because where I worked

there were other women going through the same [thing]. We were all much of a same age group.

My mother always said that she had very bad flushes and of course in her day whatever you went [to the doctor with] you got a tranquilliser for, even for Change of Life! That was what was wrong with you. It didn't matter what they had wrong with them it was always put down to...being menopausal...and of course she went through a fairly bad time. Seeing my mother when she...had [hot flushes] and she would get something out and fan herself, I thought I would do nothing that would draw attention [to myself when experiencing a hot flush]...I found that what helped me the most when I got a flush (people talk about them coming from the feet, that didn't happen to me all of a sudden I would just be conscious that I was hot)...I always would quietly just stand up and just move in my chair and [the flush] would just go. I found that that's what helped me but I never ever said anything and would [not] because my mother was terrible. For years [she would exclaim] 'I've got a flush, I've got a flush' and you know [I thought] if I am going through it I will go through it as quietly and unobtrusively as I can. I [also] worked with a lady that used to do the same thing as my mother and she suffered more than I did. And I said to her, 'Just loosen your cardy [i.e. cardigan] and try that and see if it helps' but she would pick up a fan and she would be fluffing around.

I had terrible night sweats. For the first time in my life, for two years I slept through a cold winter with one blanket on and a very thin nightie [i.e. night dress] and I have never done it before or since (if you see me now I just about wear my overcoat to bed to keep warm). I would just wake up in a bath of perspiration. I would just grab something half asleep and wipe myself down a bit and I would drop back off to sleep. I can remember [it was very tiring]...if I have a bad night, even now, when I get up in the morning I always make a point of never remembering that bad night, and I am just lucky that I can do that and I don't let it worry me or sort of think, I had a bad night last night. Will I sleep tonight? I don't do that, I won't let myself do that, so...but I mean I did get tired. I got very, very tired.

My husband was very unsupportive.... You see from past experience it was no good telling him [how I felt] anyway because I mean the comment I would get back, I didn't want to

hear it anyway. There are some men that are good with their wives and are understanding. I had a brother-in-law like that and they had a great relationship [but often] you can't talk about your problem because you become a moaner, a nagger. When you have got somebody who is very unsupportive, you...just don't leave yourself open anymore. So I just got on with it. I [found] that we do need ourselves boosted up...you know a little bit of affection sometimes...and somebody comes along and just says something nice out of the blue and it's amazing how it makes you feel. It gives you a lift.

I developed a pain in my side. It was like 'after pains' from when you have baby and it used to pull at my knee cap and I went to the doctor with that. He didn't know what it was but my sister said to me 'You will have it for about twelve months, it's your ovary'. So I just used to take the odd 'Panadene' if it got bad and she was exactly right!<sup>1</sup> [In] twelve months it had all gone.

Well when I went through [menopause] I always used a time factor that helped me go through. I would say I have only got so many [months to go]. Two years I told myself. [It will take] two years. From what I had read, generally...the last [period] had to be stopped two complete years and then...that was classed as being through the menopause. So that's what I went by.

I still had flushes [at the end of the two years, but] I was glad to get rid of the period. It was the one thing that was really great...no more periods. Oh wasn't that lovely! I had a sister-in-law who went onto HRT because she was having a bad time with depression and things like that and she got her period back. At the time all this about osteoporosis had come out and I thought, 'Oh perhaps I should investigate that' because I am supposed to be [at risk] being small boned and fair and light, and then I thought 'Oh you have to get your period back!'

### **Jackie\***

*Aged 61, Jackie\* is an in-depth interview respondent. Originally from England, Jackie\* emigrated to New Zealand thirty-five years ago. She and her husband have lived in the Feilding-Manawatu district for twenty-three years where she works as a social worker and*

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<sup>1</sup> 'Panadene' is a proprietary pain reliever.

*her husband is a teacher at the local high school. They have four adult children and Jackie's\* ninety year old mother lives nearby. About ten years ago, while working as a hospital social worker, Jackie\* was involved in running menopause education programmes in conjunction with the New Zealand Family Planning Association.*

[M]y memories go back I suppose to my youth...and sort of hearing things like, well you go funny and you go crazy and you do all kinds of strange things when you go through the menopause. Basically I have never ever talked to my mother about any of those kinds of things, including sex or anything to do with the female body. My mother signed a little thing at school to say that I could be taught at school...and then when I had my first periods and I went and told my mum, what I remember was that [she] and dad came into my bedroom that night and my mother said to my father, 'She's a little woman now'. And that's all I remember. I mean my mother tried to make me wear corsets when I was about thirteen or fourteen. I am talking whale boned corsets! She was that generation for whom a woman's body went into a corset and [she told] me I would never have a figure if I didn't wear my corsets....it was that mentality.

I remember...[my mother] had a hysterectomy, probably when she was about forty-nine or fifty and she made me (and I use the words 'made me') go to the doctor with her and I always hated it. I suppose she was leaning on me. I am an only child. I remember going to the doctor's with her and...I was there when the doctor examined her and he asked my mother if she was pregnant and my mother was horrified. Afterwards, it must have been on the way home, mother said to me, 'I am not pregnant. Your father is very understanding, he leaves me alone'. That's all I know, that's probably about all that my mother has ever told me. I presume she must have had a fibroid or something because she had a hysterectomy after that.

[My mother] would have been in her fifties when she came out [to New Zealand] and I was newly married....[S]he would have been grieving for my Dad, but maybe she was going through the menopause. I mean she never told me and I wouldn't have understood anyway. She might not have known [these things herself] and we had some quite difficult times because she really tried to hone in on me a lot. I looked on it as a dependency thing, but maybe it was related to menopause. I don't know. [W]e have never talked about it. And I have never talked to my mother at all about my own [menopause]...never said a word!

I didn't [know anything more about menopause, or] I don't think I did. I guess I started to try and find books...and find out about it when I realised something was happening and I don't ever remember in my young[er] years ever thinking about menopause. [I realised that something was happening when] I started to flood. I flooded several times and had to go home from work [and] when I think about it, it actually would have been starting quite some time [before then]. It was definitely in the early eighties because I remember having to change my clothes when I was [at work]. I have got distinct memories [of when] I ran the student unit at the hospital and I remember the students all being in there and me flooding right the way through my clothes (it's not joyful)...and having to come home to change my clothes. That's how bad it was. So I guess, in retrospect, those were the signs and then I had these sort of palpitations... and I remember going to [see the] doctor.

When I went to my doctor, I...asked him what was happening [to my body and] he couldn't tell me. He didn't say, 'I am sorry Jackie\* I don't know', but it was obvious that he didn't know, so that's what made me start to do my own research and find out. He wanted to put me on pills (my doctor is a great pill man). I think he started talking about HRT and I didn't feel that [was] the way to deal with it. I wanted to know what was happening and how it was happening and what I could do to deal with it. So...I suppose in a way I went out on a journey of self-discovery. So I got the books. I buy books [and] I have got some books on the menopause up there [on the book case]. My daughters gave me a book, I think it was [written by] the Boston Women's Health Collective. [I]t's got a chapter [on menopause]...so in a sense I think my daughters [educated me] because they introduced me to things that I hadn't necessarily thought about.

I had very hot flushes and I still get them, but not as bad, pretty regularly...most nights. It wakes me up at night [and I also get them] in the evening time but it is not as bad. I call them warm flushes as opposed to hot flushes! I used to flush so badly at night that I would wet my bed...yes [have to change it] and I woke up one night and I got out of bed and I was really woozy. I remembered (because by that time I had actually done the menopausal workshops) what it was. It's the same as you get with heat exhaustion. You know, when you lose all your electrolyte balance. And I thought that's what I have done, I have sweated so profusely [that] I have upset my salt balances and I had some 'Sustagen' I think it was

called. [After that] when I was sweating profusely, I would take a drink of 'Sustagen' and I never had any more wooziness.

I think [it's] probably true [that I sweat more since going through menopause]. Often when I am sitting down in the evening and I am perhaps watching TV, I suddenly become warm. It's a sensation that is less severe than it was, but it creeps up my arms and it creeps up from about here up [middle of the abdomen]...momentarily perhaps. [I do not get clammy] now but I used to and as I say I would sweat to the point of wetting my clothes. I mean I used to have it in the daytime as well. How did I deal with it? What I do now? If I am teaching in the class room and I am hot I say, 'Is it hot or am I having a hot flush?' and I will do that anywhere. [People just] laugh and we just carry on. I decided it doesn't matter whether it is men or anything, I just come out with it now. Because I mean often...it is hot...the room is clammy...and people will say, 'It is actually quite hot today', and we will open the windows. So, I actually bring it out into the open, except with my mother.

I [avoid certain foods]. I quite liked curries and hot spiced foods and my husband loves them and there was quite a few times of tension over the years when I said to him, 'Please don't make a hot curry'. We have certainly been more careful about our diet [in recent years]. We don't eat white bread anymore and we make sure we eat lots of vegetables. I think probably the menopausal was a time of me actually looking at lifestyle [it] has precipitated changes in our diet. I am also conscious of when looking at the menopause you are also looking at things such as...the onset of osteoporosis and...that you need to exercise and stuff like that. So although I have not been as good as I should, I try and exercise. I take the dog for a long walk and I don't stroll, I walk and I try and swim as often as I can. I mean I became much more conscious of the things that I needed to do to be healthy and I think [that consciousness] was probably precipitated by becoming much more aware of my own body.

I am just trying to remember [how I became involved with menopause education]. It was while I was at the student unit [which was part of] Community Health. I really don't remember whether the Family Planning Association (FPA) approached me or I approached them, but what actually happened was that I did the training with FPA for the purpose of running their workshops. I ran workshops on menopause [in Palmerston North] in the mid-

eighties. We [got many women coming but] we only had a small room so we had a limit of about eight to ten in the group. I also ran one here [in Feilding] when I first came back in 1989 to work in the Feilding office of Social Welfare. They had a health display down at the Community Centre...and I did a two hour session on the menopause and I had a lot of women turn up. I think I had a video and I had some handouts. Certainly I was amazed at the number of women that turned up and they looked as if they wanted support, which I wasn't in a position to give them. I think they were all women who wanted to talk about their experiences. In both Palmerston North and Feilding...they were women wanting to talk about [menopause]. The other thing I did [was] to address a meeting...[out in] the country somewhere [in] somebody's home to a group of women who were of varying ages. One of the messages we got from the old women in the group was, 'I don't know why you are worrying about all these sorts of things, we just went through it'. I remember that distinctly, [that menopause was] not an issue, you get on with life.

I think [women] need to talk about [menopause] and I think we need to find ways of dealing with it. I am really concerned about HRT [as] the medicalisation [of menopause]. They medicalised childbirth, they took childbirth away from us and they are taking this away from us as well and they are making money out of us. [My] friends who are younger than I...are sort of catching up now and they are starting to talk about menopause, but I actually haven't talked (except in a professional kind of way)...to other women about it. It's not one of those things that you actually talk about in company...it's not something that comes out with the general discussion in the tea room. Now I wouldn't want to talk to my eldest [daughter] about menopause because she wants to have a child and hasn't had one. Whereas for me the menopause meant that I could no longer have any children and was not an issue, [for] my daughter it is likely to be something entirely different. And there are [other] things about the menopause [that] I don't want to tell my daughters. [For example], that at sixty I am still having warm flushes. I don't want to tell them that...because I don't want them to know that it is still a bit of a nuisance. I mean, it's one of those things. If they want to talk about it then I will talk about it, absolutely.

It is very difficult, I think...physiologically, to in actual fact differentiate [between] what's menopause and ageing. I mean menopause is the cessation of periods, but where is the difference between that and general ageing? I haven't always worn glasses so obviously my

eye sight is going and I have got arthritis. I am not as agile as I used to be [and] I am going grey. So I mean what is the difference? How can you say it is menopause and how can you say it is ageing. I just see [menopause] as part of the ageing process really... just part of the natural process. Every time I see Zsa Zsa Gabor or Liz Taylor [in the media]... I just wonder how much HRT they have been taking and for how long. You open the women's magazines and they are all about being made over and I mean I have got no [objection to that].. I get my hair done this afternoon, for goodness sake, I am going to get my hair permed and... I had it streaked to lighten it a bit so it doesn't look quite so grey. Obviously we all want to look younger, it makes me feel better but... I guess one grows old gracefully. We have all got to die at some stage.

I suppose... I have tried to deal with [menopause] very positively. I mean the nicest thing about the menopause is that now I can wear white pants and I don't have a period anymore and that's very positive, absolutely. I think I thought that when I went through the menopause I would suddenly become all wrinkled and I would look terribly old but actually the fact [is that, while] I am ageing of course, no major changes occurred. I stopped [menstruating] when I was about fifty-five [and] nothing dramatic happened. I still haven't got any wrinkles and that's to do with the sun and its got nothing to do with the menopause I think. The doctor was always on about HRT, but I read a lot of stuff about that and I was very reluctant to take anything that was artificial because menopause is natural, puberty is natural, menopause is natural. Why should you need something artificial? It's not a disease! I know [doctors argue this] and they treat menopause as a disease. I mean who bloody wants children when they are sixty! No, I don't go along with [the disease view of menopause], I mean, I would like to hedge that by saying if women are having real distressing symptoms then of course they should have some relief. [Menopause] is nature saying, 'Hey you are too old to have children. It's time you opted out and let somebody else take over'. I know its not a disease... it is nature. You just get on with it and that in actual fact is my attitude. There are times when I feel a bit low and I will think, 'Oh damn this'. But my general attitude has been that this is natural, this is life and you just get on with it.

**Barbara\***

*Aged 57, Barbara\* is a focus group and in-depth interview participant. She has lived in the Feilding-Manawatu district for all but five years of her life. Married to a retired butcher and the mother of five children, Barbara\* is active in her church and a number of community organisations including 'Friendly Wives'. A full-time housewife, at the time of the interview she was preparing for Christmas and her cake was baking in the oven.*

I have never had any trouble with my periods and I have just flown through [menopause]. Everything has been real good and I am just in the last stage of it now. I suppose [it started]... a couple of years [ago when I got] the first hot flushes. I haven't had any hot flushes for months and months [now]. I have missed three periods and now I have got [my period] again and it has taken longer than a week...you know just dribbling along. So I might go another four or five months now and not see it again. So it will gradually [go] I am hoping, I am really sick of it now. I don't know how long it is supposed to take. I [have] just turned fifty-six so I could go another four years.

I suppose, our generation, they don't talk about [menopause]...the ones I get around with don't seem to say much. I am one of those people that it doesn't worry me [to talk about it]. Most of my friends have had hysterectomies and they work, so I sort of haven't got a lot of contact with them at the moment. They are busy. [I only knew] just what some friends said. [That] they have got hot flushes and it's driving them crazy. I always remember [what one friend said], 'Oh what a night I have had! I had to get up and my husband changed the bed for me while I had a shower'. She said [she had] 'Just flooded everywhere!' So you know some people must go through a bad time. But that's about the only person I have heard that's done that...just hot flushes in general, that's all they have said. You know it just about drives them crazy. I just sort of accepted it, that [menopause] would come one day and I would just go along with it.

I can remember Mum... going through the menopause. Hers was just a breeze too. She told me it took ten years...probably say from middle forties to middle fifties. [She] just [had] the hot flushes and that was all. I can remember my grandmother told my mother and my mother told me that hot flushes were worth their weight in gold, [and] never to take anything [to stop them]. Well [my grandmother] just said they were there for a purpose and they were good for your body. So I have never [taken] anything [for hot flushes]. [I have]

never sort of thought, 'Well I don't want [hot flushes]'. Of course I [thought of] what my grandmother said, that [a hot flush] is good for you, 'Let it go, go along with it'. The hot flushes are gone [now]. I suppose...I would have had them...for a couple of years. I [did have] sore breasts [and night sweats], but not bad ones that you have to get up and change your nightie or anything. [I] just put [my] feet out the side of bed and of course they only last for about a minute at the most, probably only thirty or forty seconds and they would be gone. [It was] just the odd one here and there...it would be only one a night. [I would wake up] just feeling hot and once it was over that was it. Yes, [I went back to sleep easily]. I have always been such a good sleeper. I reckon that's got a lot to do with everything...it's probably just helped me go through the menopause. I've never gone to the doctor, [I have] just sort of sailed through [menopause].

I had a serious [heart attack and] nearly died! That was ten years ago. Mum died in the September just before her sixty-eighth birthday and the next Easter I took a funny turn and just about never came back...I was only about forty-four or forty-five, so I had a massive coronary and then a year later I had a stroke! [It has] been nine years since the stroke so...nothing since, no. I said to my doctor, 'Was it the shock of losing my mother?' because we found her dead in her chair...she had been there all night and I just couldn't accept it and get over it, because we saw her three or four times a day you know. It was the stress of it. It was stressful! I missed...not being able to ask [her] about things, even if it is just a recipe like at Christmas time. Mum always made my Christmas cakes, [so] I had to start making my own. [Mothers] are so good to you aren't they? It is just so hard to take, [she] was always here. We were the best of friends.

The doctor told me at my last check up for my heart...that he thinks that I will do well on HRT and he wants me to have that because they have discovered that it would be good for the arteries...so I will give it a go. He wants me to think about it and when I go back to him for the next lot of [heart] pills (that's in three months time) he will put me on [HRT]. I have talked it over with my husband and he said, 'Well...you do what you think', but I don't know [about possible] side-effects! [The doctor] said that there is one. I have only heard from people talking that you get your period back again and I said [to the doctor], 'Oh I don't want that once I am sort of just about due to finish!' [The doctor] said, 'No. I

could give [you a pill] that stops [a bleed] altogether'. So I don't know whether that's [possible].

[I haven't heard much about HRT] because I was never going to have it! I mean...well different girls had said, well it was expensive and we are not getting any money coming in much now and I thought well, 'I won't be able to afford it'. I thought it might be quite dear every time you get your tablets.... And that was another thing, I have got four lots of tablets to take. Like four in the morning, three at dinner time and another three at night and I thought, 'Oh golly! I wouldn't like to...upset them!'. [But the doctor] said go home and think about it. He said it would be good for me, especially with my heart. He's lovely, I really like him. He is about the best doctor I have had anything to do with. You can just sit down and he calls you by your Christian name and then he says this and he brought it up. He was lovely!

### **Beverley**

*Aged 54, Beverley is a New Zealand Woman's Day respondent and the mother of three children who resides in Auckland. Separated from her policeman husband, Beverley runs her own business that involves 'manufacturing, wholesale, retail and export of handmade ceramics'.*

My menopause started at age fifty or that is when bleeding became irregular. My bleeding stopped for good after about a year. I had also an occasional hot flush. I have not needed any medical treatment.

At age forty-eight I calculated that if I stopped bleeding at age fifty and with a period every twenty-five days there were about twenty-eight more periods and at approximately ten dollars per time (pads, tampons) [plus the] inconvenience, I decided that was enough!!! At that time I was doing a lot of reading of 'self-awareness' and 'positive thinking' books [and] I gave myself the affirmation 'I am menstruation free, and my hormones are in perfect balance'. I said this several to lots of times a day, every day. By the time I got to age fifty I would go longer between periods although they were still heavy. At about fifty-one I seemed to have stopped bleeding and after about six months with no period, I gave myself a new affirmation. 'I am hot sweat free and my hormones are in perfect balance'. I say this every day usually on my early

morning walk along the beach with the dog. I am a firm believer that the mind controls the body.

Yes, I have had hot flushes and night sweats. I tell them that they are not necessary. Reaffirm my affirmation and get on with whatever. Vaginal dryness is not a problem at present as I do not have a partner, but if necessary there are plenty of lubricants on the market.

I have found the whole process easy and positive. Some people think I am a bit funny. I don't talk about it, and get on with life. It is wonderful not bleeding, I always found it a chore. Not to have to think what you will wear in case you flood through everything -it is very embarrassing!!

Most attitudes that I have encountered from friends have been supportive. In my experience menopause is discussed [among women]; it is very hard to hide a hot flush! I did buy and read Sandra Coney's book and the subject of menopause has been openly discussed with friends.<sup>2</sup> I agree with Sandra Coney, [HRT is] good for the drug companies. I suppose it does have its place and everyone is different. For me, I don't want to bleed again! I [have] never discussed [menopause] with my mother [who] died twenty years ago.

I think menopause should be promoted as a natural process, not a disease. Women should not be considered as 'past it' or 'past use by date'. I feel good about menopause. I found bleeding an expensive inconvenience (if men had to put up with bleeding every month there would have been a subsidy or free pads and tampons years ago).

### **Marilyn**

*Aged 51, Marilyn is a New Zealand Woman's Day respondent from Auckland. Marilyn's husband is a plumber and they have two adopted sons. She is active in a number of voluntary organisations in addition to holding a full-time managerial position.*

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<sup>2</sup> Coney (1993).

For me [menopause] started at thirty years of age [and] I am still experiencing [it] at the age of fifty-one years.

[When] I was sixteen [years old]...I was admitted to hospital with suspected appendicitis. The house surgeon told [my] mother [that] a small cyst had been found on one of my ovaries and the cyst had been removed. The report [that] went back to the general practitioner said nothing had been found. From then on I had problems. During those years from when I was sixteen until I had the hysterectomy when I was twenty-nine I had been treated with different medications including the contraceptive pill on and off. I finally went to a specialist recommended by the doctor who had been my general practitioner when I was growing up. The [specialist] he referred me to was wonderful [and] I was under his care for about a year before he suggested that he believed that a hysterectomy was the only answer. When I had the hysterectomy it was found I only had one ovary [and] it [was] suspected that [the other] ovary was removed when I had the surgery when I was sixteen. I have not regretted that decision [to have a hysterectomy]. [I have] only felt sadness during what would have been my childbearing years and [when] seeing pregnant women.

I have been receiving medical treatment from the outset of menopause [as] I experienced severe mood fluctuations, hot flushes, dry skin, vivid dreams [and a] lack of self-confidence. At first I was prescribed HRT to be taken for three weeks followed by a week's break and then three weeks etc. This occurred for approximately three years. It was okay while I was taking the medication but once I stopped it was 'Back to square one again'.

I can remember at the onset of menopause the doctor was not overly helpful, probably because at that time most doctors did not know much about it. I happened to be at a coffee morning (when I was about thirty-three years of age) and the speaker was [someone from] the Family Planning clinic. Her talk was not about the menopause so I asked her during morning tea if they offered any support for menopause clients. She suggested that I should make an appointment to see Dr. Alison Riddell (who at the time was renowned for her research and work on menopause). It was one of the best appointments I have made in my life. Dr. Riddell advised me to take Pryidoxine [in

addition to HRT).<sup>3</sup> After several visits she also advised that I should take [HRT] continuously without a break [as] having a break...was just [sending me] back to square one all the time.

From the age of approximately thirty-three to the age of forty-six I [was] taking HRT and Pyridoxine. For the last five years or so I have also been taking calcium. The medication has certainly helped me. While I still have dreams they are nothing like [those] I was experiencing all those years ago. [At that time] I was dreaming from the time I went to sleep until I got up. I used to drag myself out of bed thinking, 'Another nine hours and I can go back to bed!' With two pre-schoolers at the time, it was hard [and] looking back I wondered how on earth I coped!!

Approximately six months ago I asked my doctor if it was necessary [for me] to keep on with all the medication. Following [the] discussion with him I was sent for a bone scan test [which] revealed that it is necessary to continue with the calcium replacement for the rest of my life. Even more important [was the fact ] that as I have a high cholesterol level, I cannot have too much in the way of diary products and because there is a history of heart disease in the family and research has shown that HRT can prevent heart attacks in women, [it was decided] that I should continue [on HRT]. Because I get a prescription every three months, I try and have a break [from HRT] to see if the symptoms have gone. They haven't [gone yet] so I keep on taking the medication.

I know...that I couldn't have got by without [HRT]. I am fortunate in a way that I have had a hysterectomy so there is not the danger of cancer of the cervix. I have regular mammography's and smear tests. My doctor also checks my blood pressure and heart every three months. I believe...women need to be aware that help is available, you don't need to suffer. Women don't need to be patted on the hand and told, 'It is just your age dear!' What they need is information [that is able to be] clearly understood, [on] the pros and cons of taking HRT. It is really hard to know at times what to believe when you get such opposing points of view. All you can do is discuss

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<sup>3</sup> Pyridoxine is Vitamin B<sub>6</sub>.

the issues, talk about the pros and cons and make an informed decision. It is important that we ask questions of our doctors. We are entitled to know!! My doctor has been much more helpful over the last few years - I have also come to the point of asking questions.

I also believe that men need education on the menopause process. I acknowledge that while I was going through hell all those years ago (hey we are talking about twenty years ago here) my husband was probably feeling he was walking on egg shells too, to say nothing about my children. My mother-in-law had gone through a pretty rough time apparently (according to her off-spring) and she had been older (approximately in her fifties). I can clearly remember my husband saying to me, 'But you are not old enough to be going through that'. I guess times have changed and men might [now] be more understanding. Probably what I am saying is [that] education for all is what is required and [that] women should be encouraged and supported [and that during] this part of life help and support is available.

In the early years I was feeling really bad about [menopause]. I was feeling constantly drained and at times, looking back, almost suicidal. However, once I was on the right track with medication and information I have felt much more positive about the whole thing [and] in fact I don't think about it any more.

### **Pamela**

*Aged 50, Pamela is a New Zealand Woman's Day respondent and the mother of three adult daughters. A retired Taranaki dairy farmer, Pamela and her husband now reside in New Plymouth. She wrote, 'I feel I have bared my soul but it has been a great help to me writing all this down'.*

I am...in the process of menopause, which is an oblique word in my opinion. No-one seems to be able to tell me exactly what it is! I know it is the ceasing of your periods but when exactly are you menopausal and when do you become normal again? Someone told me that [you reach menopause on] the last day of your last period but most people seem to have irregular periods for several months, even years, so that's a wee bit hard to pin down. [I was also told] that when the hot flushes stop that means you're out of [menopause]. Some women have hot flushes in their seventies! Dear God

is that what we all have to look forward to? Twenty years or so of it! I cannot find this information. Books have been written I know, but most of them waffle on and repeat themselves.

I...ha[ve] had what I will [call] (and you will have to excuse me for it) a real shitty time of it, with little or no help at the beginning and I have struggled to keep sane for the last few years. I suffered from PMS quite badly with cramps, mood swings, bloating, swollen ankles, spotty face, greasy hair and generally being quite miserable for a couple of days before my period finished and about a week before it started....I would always feel and look fatter and was pleased when I got [my period] because after a couple of heavy days bleeding I was okay for a couple of weeks before it all started again.

I think I started having a few hot flushes at about forty-two years of age but [I] really didn't associate them with anything and at forty-five [I] really started to have trouble. I am still in [menopause], I think! I experienced a lot of symptoms and associated them with menopause from what I had read. I suffered hot flushes so severe that I thought I would faint. [My] head, hair and scalp would be burning and I would gasp for breath. They sometimes lasted two or three minutes. I would be in a T-shirt in the cold of winter. We lived near a mountain and I would still be hot, I counted up one day and had one hundred and ten hot flushes! I was exhausted. At night I would get very hot and sweat and...throw off the bed clothes and cool down. Sometimes I would have to change and soon as I cooled down I would get cold...very cold [and] I'd shiver till I got warm and then just doze off and then it would start all over again. By the morning I was like a dish rag!

I would never sleep during the day as I would have weird, really weird dreams that were almost frightening (not nightmares) but so queer I wondered where they came from. I would also be so utterly miserable on some days. So much so [that] all I wanted to do was crawl into a corner and curl up and hope I never woke up. The feeling of loss and sadness was awful and I had to talk myself through those days and tell myself I'd be okay. Just to go with it and it will pass as it usually did.

I was having my periods still, even though at that time they were slightly irregular. These symptoms became worse as time went by [but] I'm not sure at what age I was the worst. I had creepy crawly skin and burning patches on my head and body. I often felt sick and all of my joints ached along with my muscles. My skin would go all dry and blotchy, would get tiny white pimples on it, especially on my nose, [and] my hair [would go] all funny...when I had a drop in hormones, as I came to regard it. I also ha[d] a burning in the mouth and tongue.

I was also under a lot of stress and worked physically hard on the farm. I would often lose things around the house and find odd things in the fridge and forget very important things which can be very embarrassing, so I wrote everything down and took notes to try and overcome that one. I had panic attacks where my heart seemed to skip beats or flutter, which made me feel worse, and I would often have to take deep breaths and try and calm down. I would cry also. I would wake up in the night with tears pouring down my face. I would tell my husband, 'I'm not feeling well' and he would understand, although he hated seeing me cry and would give me a cuddle. So I struggled through the day hoping no-one would see my puffy eyes.

My vagina was dry but 'KY Jelly' helped [and] I found this wasn't really a problem. Lack of libido was a problem. I never felt any sexual urge at times and couldn't really have cared less, but made love to my husband...so that at least he didn't miss out. [A]s I explained to him, I like making him happy and even if I don't feel like it. [H]e was patient and most times understanding. Sometimes I couldn't bear to be touched and that was awful. I hated that feeling. Nothing I could do helped. I just looked awful so I usually tried to stay home on those days and blamed the mixed up hormones.

I went to a woman doctor re my problems and she wasn't much help. She said I was pre-menopausal and while I still had periods there was nothing she could do and suggested aerobics or yoga. I was very upset. I then went to a series of homeopaths and with the help of 'Dong Quai' and a few other concoctions seem to get the symptoms under a little control for a while, and so I struggled on with them. By now I was so used to being like I was, I couldn't remember ever being normal and what it

was [like] to have a decent night sleep. Gradually, as time went by, I was getting extremely fed up with all of this.

I went to the library and read books or rather flipped through them - they're too long and weren't much help. Most said the same thing, 'It's a natural process' and 'Your ovaries are shrivelling up'. I went to a seminar put on by a health nurse last year and I was amazed at the women there (about twenty of us) who knew nothing about menopause and some asked how would they identify a hot flush. The nurse was quite good and explained with diagrams about it, but really didn't have time to listen to anyone. She gave out pamphlets on menopause and HRT and its advantages [but] there hasn't been anymore meetings or follow ups. I was disappointed because I thought I'd learn something, but I seem to know it all - more than the others - so it was a waste of time.

My last period was...two years ago and I would have been forty-eight. We went overseas and with the heat and persistent hot flushes and sweating I found it very tiring, and when we arrived home decided to see my doctor (another one) re some sort of help. I was given two videos on menopause to look at and one was excellent. I could relate to each and everyone of the four women interviewed; they all had symptoms like me and they all went onto HRT and were amazed at how well they felt. It gave me the courage (as I sat and watched with my husband) to give it a try. I felt I had succumbed to it out of sheer desperation. After going all natural for years [and] practically living in the health shop, I felt I was betraying my body by going chemical! But after seeing these women on the video saying they sleep at night and feel refreshed in the morning, instead of struggling to get out of bed. [T]hat they have boundless energy and can cope with all sorts of things and their husbands are thrilled to get their wives back again (sex wise). [T]heir aching joints have gone and all-in-all [they] feel wonderful. I felt I had to have a go. So I am now on 'Menoprem' which is a very low dose HRT.

I have been on [HRT] for three months and in that time have almost cut out the hot flushes. I still get one or two a day. I sleep better, but still get a bit hot. I have a lot more energy but feel a lot better than I did before. I hate admitting it, but they're really

making a difference. I feel that this dosage is not quite strong enough [but] the doctor, who is lovely, said he'd rather start on a low dose than too high. Apparently I shouldn't be getting any flushes at all [but] I guess it takes time to sort this sort of thing out. I haven't got my libido back properly but it has improved a little. And I have had a slight bleed for eight days which upset me in the fact that it had to activate my body to do that, but hopefully it won't do that again. I'm due to go back to [the doctor] next week so I will get something a little stronger [as] I think I am getting immune to the dosage. I only wished I had had them before we went overseas for two months back in July and August. However, I think I have a stronger quality of life now even though [it is] chemically induced.

My views on HRT are varied. I... don't like taking [HRT], but I feel I haven't got a lot of choices left if I want a quality of life. After all, these are the best years of our lives where we can do all of the things we've always wanted to do. [The] kids are mostly grown up and don't need you and we should be generally healthy and full of the joys of living. So if HRT can give me that then so be it. I've tried all the alternative medicines, naturopaths and healers etc., but they just don't work. I sometimes wonder at the logic of it all, when if you take HRT you help your bones and protect your heart... but run the risk of cancer, which I've been assured is not very great. So if you don't take HRT your bones will suffer later on in life and you could have heart trouble etc. [It] seems to be a case of the lesser of the two evils. I often wonder at Lynda McCartney (Beetle Paul's wife) [who] had her breast removed when she was fifty (poor woman) but she had a vegetarian life. I wonder if she was on HRT?

I don't think I ever really discussed [menopause] with my mother as we were not very close, and I know that generation don't like discussing that sort of thing. I think she went through hers early because she screamed and cried a lot and was very, very hard and strict on me. When I look back now, I guess she really suffered. Sometimes women talk, but I find most don't want to talk about it, they find it embarrassing. I find that I have to watch what I say, but always have a sympathetic ear if needed. I think women should talk more... they would see they're not alone. [Most] of my friends are still having periods. One friend just stopped and [had] nothing, not [even] one symptom and she felt pretty awful telling me [because] she knew how I was. But she's

lucky and that's life! I read somewhere 15 per cent [of women] have all the symptoms, 15 per cent have some symptoms and 70 per cent have very few, they're the lucky ones. I don't think it has anything to do with lifestyle or outlook.

Most people put down the slightest thing to 'the change'! It can be awful in some work places with men; they need to be educated on the subject and [how to be] very sympathetic to all women. Most of my family are really great. I suppose having it first hand. My three daughters (aged twenty-two, twenty-six and twenty-eight) are very supportive and I think they have a greater understanding of what does happen to some women and maybe will be better prepared when they reach that age.

How do I feel about my experience of menopause? I feel it was the worst five years of my life. Absolutely devastating and I wouldn't wish anyone to have to go through what I did. I felt I had struggled long enough on my own and the thought of another ten years like that was extremely daunting...I don't think I could have coped any longer.

### **Marie**

*Aged 50, Marie is a New Zealand Woman's Day respondent who lives in Nelson with her husband who is a stevedore. Marie has an adopted teenage son and daughter, and works as a school administration officer.*

[I] went through menopause at forty-seven and [it] lasted two years. [The] symptoms [included]: hot flushes, forgetfulness, headaches, hot sweats (nights only), tearful[ness], irregular periods [and] insomnia. [I thought I] was going through menopause because of [my] age and [the] irregular periods....I asked my practice nurse if she had any information on menopause [and this] confirmed to me it was.

I discussed my symptoms with my general practitioner and [it] was suggested I go onto [HRT]. My periods had already stopped five months previously (the best part of menopause) and I was told [that] once I started on these tablets my periods would start again. I was also told that, although not proven, there was a 'thought' amongst the medical profession that these tablets could be a cause of breast cancer. I just wanted relief [from my symptoms] so agreed to take the tablets. The treatment lasted

from 31.1.95 to 12.6.95. The hot flushes and hot sweats stopped but nothing else. Also I developed a pain in my left breast which I blamed at the time on the tablet. Looking back I think I got a bit paranoid about the breast cancer warning [and] now think it was indigestion. My periods also returned.

I met Sally, a homeopath. On my first appointment I was prescribed *Sepia*. I didn't take it straight away as I wanted to tell my general practitioner I was coming off HRT and trying a homeopath[ic] remedy. After all, it was my choice and I wasn't happy on HRT. My general practitioner was most supportive which surprised me. After taking the 'Sepia', my mental state improved and my attitude to my family and work improved. [On] my second and third visits I was prescribed 'Lachasis', which had a marginal response. On my fourth visit I was prescribed sulphur. May I add here that I have been plagued by indigestion for the past thirty years and was on 'Tagamet', as well as HRT. Now I am on the sulphur I am free of indigestion as well as my menopause symptoms. I now have a quality of life.

Now that I have found homeopathy, I wouldn't touch HRT. There are no side-effects, [it is] non-invasive, no pills to take. [I] have a better quality of life than before because HRT does not address or enhance your life all round. Homeopathy is a very individualised form of medicine.

Menopause was something I dreaded after hearing other peoples' stories but I think I am one of the lucky ones, well so far! The worst for me would be the flushes and sweats and tiredness. Over the years I have piled on the weight and believe if I lost some I would feel better still.

### **Monique**

*Aged 48, Monique is a New Zealand Woman's Day respondent. She lives in Rangiora with her husband who is a logging contractor. They have four children aged from twenty-two years downwards. In the past, Monique has worked as a nurse aid at the local hospital. At the time of writing she was on the waiting list for employment at Rangiora Maternity Hospital. She wrote. 'I did not achieve academically at all at school. I was shy and timid and easily distracted [but since then] I [have] read a lot and have educated myself through reading biographies and real life stories'.*

I think I must have started the lead up to the menopause in my late thirties because my periods were heavier, [the] headaches leading up to menstruation [were] worse and lasted longer (several days) [and] PMT [was] much worse. I would get very upset and nearly lose it sometimes. All the time I had no idea I was nearing menopause. I didn't even suspect I was heading that way. I thought it was to do with raising a family of four (one son and three daughters) and the stresses that come with bringing up teenagers. Their criticisms and belittlings tended to affect me.

Before the menopause I looked on it with trepidation, simply because I had read over the years, starting from a teenager, bad things about it. I ha[d] discussed the menopause briefly with my mother but she wasn't terribly forthcoming as women in this age bracket (seventy plus) didn't discuss private things like the menopause [and] her attitude was that you just got on with it. Her mother was more reserved still.

The actual start of the menopause was at age forty-two with my periods coming at every second month at the beginning for a few months [and] then four monthly. I remember saying to my husband that I wouldn't mind having another baby and wondered if I was pregnant but when my period arrived I wasn't disappointed. It was just a silly notion I had at the time. [I was] around forty-five when I had my last period which came a whole year after the second to last one. It was a relief to have no more periods to worry about. This to me was the best part of the menopause. So around four or five years it took.

I experienced hot flushes (these haven't finished yet), tension, mild panic attacks, when tired mood swings, forgetfulness, being short fused. The hot flushes and panic attacks were new with the menopause [while] the other symptoms are part of my temperament but have been heightened during this time. I have had hot flushes now for five years. These did not start until after I started missing periods. My mother had them for five years and mine haven't finished yet and are worse during the summer months. They seem to disappear altogether during the coldest months which is very nice. I only thought of them as terrible when I was asparagus picking and working in thirty degrees plus some days. I seemed [at this time] to have one hot flush after another [and] that was hell on earth. I [also] experienced mild panic attacks and nervous attacks...in

stressful situations; for example, standing in queues, waiting in traffic jams, or if I am tired. These attacks don't happen very often (thank goodness). I have never had therapy or counselling of any kind as I feel I can manage on my own with a strange mental outlook and the odd prayer when things get foul. It's only in the last year or so that I have felt more settled.

I sought information on the menopause from the library just to put my mind at rest. It was comforting to know I wasn't the only one going through these things. I didn't take medical help. I chose not to as I didn't know if I would react [well] to HRT [and] I don't like putting things like that in my body. Having been on the pill for three months after my second child was born I didn't feel normal and my legs ached. I would have only taken [HRT] for hot flushes anyway. As I am still experiencing these, I have learned how to cope with them even if they are a nuisance. [I have found that] the right mental approach and a strong mind can help you deal with things a lot better.

My menopause hasn't been as bad as what some poor women have to go through, though. None of the symptoms [were] really bad. My husband has been pretty patient through it all putting up with my tantrums and mild depressions. We don't realise how stressful it can be for them also. So one [cheer] for the husbands and partners.

I feel quite proud of myself for having coped with menopause and raising teenagers at the same time and doing quite hard part-time work asparagus picking and apple picking. It really is better to go out and keep busy. Do something which takes you away from yourself. My final comments are that 'the change of life' needn't be the dreaded 'lurgy' [i.e. ailment or 'plague'] it was once considered to be. With more information and support groups it should be approached with less fear and mystery.

### **Ainslie\***

*Aged 47, Ainslie\* is a focus group and in-depth interview participant. Ainslie\* and her husband, an engineer, have lived in the Feilding-Manawatu district for ten years. Ainslie\* is the mother of two adult children who have both left home. At the time of the interviews Ainslie\*, a qualified dressmaker, was employed as a machinist for an outdoor equipment manufacturer. Her husband, Geoff, participated in the personal interview and when asked about the impact of Ainslie's\* experience on himself,*

*remarked that he 'realised that [menopause] was something beyond [Ainslie's\*] immediate control [and that] she was doing her best to control it'.*

I was really quite enjoying my forties for a year or two and then all this started. I was always led to believe that [menopause occurred] nearer into the fifties. [So] you see I didn't really think I was old enough and I kept thinking this isn't for me at this stage. [When the symptoms appeared] everyone kept saying to me, 'Don't be stupid, not at your age!' I didn't go to my doctor for two years. I put up with the dry vaginal problems, we basically never had sex for two years, [and so on] right down to the insomnia for hours and hours on end at night. I couldn't sleep. I got hot flushes. I would wake up that hot. [My husband] just kept saying, 'This can't go on. There has to be something sorted out in it' and I kept thinking, 'Oh it can't be yet!' In the end my husband said, 'Don't you think that you need to talk to someone?' I was only forty-two at this stage.

I went to the doctor [and] said, 'My husband sent me'. [The doctor] told me that almost every woman that came said... it was the husband who was sick of the problem. That [the husband's complained] either that you didn't want sex or that it was painful or something that affected him. So it was [the husband who] motivated [the woman to seek medical advice]. I felt very relaxed the whole time I was there talking to [the doctor]. He was just so easy to talk to once I started. Mind you, I felt that I was almost in tears by the day I got there and I could have cried. I think I cried a lot and I just kept thinking, 'He will think I am stupid'.

[The doctor] was very, very helpful but he just automatically put me on HRT. [He] just said, 'We will put you on [HRT] for five years and re-look at the thing then. Just pop into the surgery and just pick up a prescription every three months'. [He] told me [of] all [the possible side-effects] and [I] thought they [were] outweighed [by] the problems I had. It was like this wonder drug...and that was what really made up my mind, because [the doctor] said to me, 'You don't have to go on it over night but I will give you the prescription and read this information...and make up your own mind later'. I think he put me on [HRT] for two reasons, because...at the time I crushed my tailbone and ripped all the muscles up my back...and it was an easy way out. It was correcting one problem straight away. I mean I acknowledge what he did, he did it with the right reasons...but

there was no alternative [offered]...so you felt that you had no choice but to go on it. I don't think there was enough information.

[HRT] solved all the dry vaginal problems, it solved the night hot sweats and insomnia. I slept for ten hours at a stretch! It was absolutely wonderful but the weight gain was what I just couldn't cope with and the terrible [periods]..I mean it was back to seven days. They were awful. I [had been] at the stage where I only got a period for one day...but for me, after two years, I just couldn't cope with it any more. So off my own bat, after two years and two stone [increase] in weight, I decided that I would flush them down the toilet!

I just went to 'Corn Rigs'<sup>4</sup> in Palmerston North and [saw] the [therapist] in there. I was just very impressed by the way she was. I mean I have got a real thing about people that are into crystals and witchy-type things. I can't handle those and I didn't feel that [way] going to 'Corn Rigs'. I felt she was very honest and open with me and there was nothing sort of weird about the place. She was...very easy to speak to and made me feel that I was quite important and I wasn't the only one taking something like this or doing something for myself.

To start with I was taking just the 'C-X' and then I went onto the Vitamin E combination later on.<sup>5</sup> [The therapist also] suggested that I keep a daily diary about how I am feeling and now I know about my own body more than I did before. [In the diary I record] whether I have had hot flushes today, whether I am feeling stressed, if I have a period what it's like and just generally how I am feeling so that I can actually work out now the different days of the month that I am worse than other times. I write it all down...and you can sort of tell. Some days I take an extra pill if I feel I am getting a bit funny. I sort of sense myself by mid-afternoon that it is time that I took another one. [It is] almost like [the feeling of] PMT coming on. [The therapist] told me to work it out myself. I have found that it has been a really exciting time. That's only been in the last four months.

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<sup>4</sup> A health food and products shop.

<sup>5</sup> 'C-X Herbal Remedy' is a proprietary product. The capsules contain black cohosh root, liquorice root, Siberian ginseng root, sasparella root, spore vine herb, blessed thistle herb and false unicorn root.

I felt that for the first month [after going off HRT, there was] nothing [no benefits from the herb treatment]. You have got to get herb things into your system and I sort of felt I had to get the HRT out [of my system]. So for one month I wasn't really good. [I had] horrendous hot flushes, I felt very nauseated [and] sort of felt that I wasn't my normal self, but I thought I have got to persevere with this because it doesn't happen over night. It took a month probably to get a [balance]. [Now that ] I am on a herb replacement, I have never felt so well. I have gone right back, almost instantly right back, to no period at all...as soon as I came off the HRT. And now our sex life has gone the other way. My husband is fighting me off every night. He says perhaps I could start him on some Vitamin E...after years of virtually nothing!

Until I went to the doctor I could see that there was nothing good about [menopause] but now that I have started taking control of it I can see real positive steps. I still think [the symptoms] have a lot to do with your diet. Like I have had a coffee now [and] I feel very flushed. I find if I cut my coffee down and drink hot water that I don't have half as many hot flushes. So I don't drink a lot of it and I cut that down like probably [to] a third of what I would drink during the day. [The therapist] also talked about exercise [that] if I exercise [it] would take a lot of the symptoms away and it is true. It's just as she explained. It doesn't work for everybody but I don't care about everybody else, I am worried about me. As my husband said, he is just so delighted with the way I am and people tell me they haven't seen me looking so well, so that helps.

The interesting thing for me is [that] since I went on the herb [therapy] I still haven't lost any weight but for some reason it is not the obsession it was. It doesn't matter so much...I don't feel it is a problem now. I believe that it will come off in time, taking [its own] time...I just wondered what [HRT] was doing to me and I feel better in myself [now that I am off it]. I don't care about [the weight increase] anymore...it doesn't bother me now.

I am curious as to how many people are actually on HRT and how many are not and still coping. I am curious because it seems to me that everybody, like the ones I have spoken to since...their doctors have just said 'This is what you do'. You go on [HRT] and I think we are not questioning our doctors...it's the easy way out. Everyone's on HRT, that's what you do! When I said, 'I am going off' [other women said] 'Oh you can't possibly do that!'

I mean [as if] that is just sort of like the worst thing in the world. I haven't told the doctor I have gone off [HRT]. I have never been back since November and as far as I am concerned I have got no need to go back and he has never asked me why I have come off it.

There is a definite thing about mid-life... I am going through that right now... my daughter has just got engaged and she has gone away and she's living in the town where his family are. Our son's in a flat here [in town] and I see him on a regular basis. So it is just my husband and I at home now and the house is just so [empty]. I probably think it is worse because I am menopausal... but I think maybe if it was ten years on and I had passed all this, maybe I wouldn't feel the same. I think I would be able to cope with it better. This time is like a season in our lives; I am going through an autumn in my life and I am shedding a few leaves and skins... and in a few months it will all come round again... when they get married and have children. There will be grandchildren and they will be coming back to me so that will be the next season in my life. I am trying to be positive and thinking of it as a season because I think our life does go in [seasons].

### **Christine**

*Aged 44, Christine is a New Zealand Woman's Day respondent from the Wellington area. She is the mother of four daughters aged in their twenties. Christine's husband is a builder and she is employed as a library assistant at a local public library.*

My case is a little different. No matter how many books I've read, very little... information is available for women [like myself] who have had a hysterectomy with oophorectomy.<sup>6</sup> I can't be alone with this... I had my hysterectomy at age twenty-nine. I had cysts. The specialist at the time said, 'I couldn't find your ovaries [but] not to worry, a few pills will sort out the problem'.

I was told I may experience hot flushes or hot sweats... however my problems have been a lot more severe. [I have experienced] hot flushes, hot sweats, panic attacks, severe depression, weight gain, sore breasts, milk in breasts, fatigue, memory loss, muddledness, lack of confidence, facial male hair and dry vagina. About two weeks

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<sup>6</sup> Oophorectomy involves the removal of both the uterus and ovaries.

after the operation [the] hot flushes began. I didn't feel well at all. It was a mixture of a lot of problems and I didn't cope with life in general very well.

I noticed an article in the *Hutt News* that the New Zealand Family Planning Clinic were having an evening to discuss menopause so I went along. They were kind enough to refer me to Professor Hutton at Wellington Hospital and I appreciated this. Professor Hutton spoke to me for one hour, explaining and answering a lot of questions and put me on the pill.

I had the opportunity to travel some eight years ago to San Diego and I went to a specialist there. However, I came away feeling that we had better doctors in New Zealand on the subject and as far as medication and understanding [are concerned].

I have noticed in the last ten years that there are brochures at doctors' [surgeries] for you to read. It is accepted in society that women can suffer and can be quite sick with menopause, however, I feel it is a very lonely time in your life and a very misunderstood subject.

[W]here I work seven co-workers are women aged between late thirties and early fifties so we discuss menopause and I'm grateful for this. My mother and sister have never wanted to talk about [menopause].

### **Sue P**

*Aged 44, Sue P is a New Zealand Woman's Day respondent and a legal secretary from Auckland. Her husband is a driver and they have a teenage son and daughter. Sue wrote, 'I feel this is a very important subject - every woman has to go through it but not every woman gets pregnant and there is far more information available about pregnancy than menopause'.*

I am currently going through [menopause]. I am aged forty-four and at the age of thirty-four years had a hysterectomy, removing the uterus but leaving my ovaries. At age thirty-nine I began to wake up at night briefly and would find my body (particularly my feet) burning, even in the middle of winter! I also found that the skin on my feet and arms was getting a peculiar tickling/itching sensation at nights during

sleep and whilst half asleep. I would scratch and scratch and scratch until I would wake myself up because I had clawed the skin raw and made myself bleed. There was no logical reason for this local irritation, there was no sign of a rash or insect bites. My doctor suggested he put me on 'EO' and the burning and itching subsided.<sup>7</sup>

Two years ago my doctor suggested we change my HRT to 'Progynova'. He said that gynaecologists preferred it as it was more 'natural' oestrogen. I was having no problems with [the one I was on] but consented. I had only been on it a short time when I began feeling nauseous in the mornings, eventually suffering from a daily episode of 'morning sickness'. I also began to suffer from severe dizzy spells which would make the room slowly revolve and make me feel sick too. The only way to overcome these was to lie down (not always possible when at work or out shopping miles from home) or take a Diazepam, and wait for about half an hour.<sup>8</sup> My blood pressure increased and I had a lot of fluid retention. My doctor did not seem to pick up on these symptoms but rather told me it was all stress, which it most certainly was not. Finally, I said I wanted to go back on the 'EO', and within days all the previous symptoms had disappeared. I changed doctors as well.

I am generally a good sleeper but occasionally (like about once in four months) for no apparent reason I will go to sleep, wake up after half an hour or so and not get back to sleep until about 4am [and] then have to get up at 6am to prepare to go to work. However, I would always know I would catch up on my sleep the next night. [But] during 1995 these episodes began to increase. From [every] four months it went to about once a month and suddenly, since July, it [has] escalated to once a week, twice a week, four nights a week and finally every night or second night when I would go to sleep, wake up after an hour or so, drenched in sweat, and so wide awake it was impossible to go back to sleep until about 4am, if at all. I might add that I rarely perspire under normal circumstances, even on the hottest days. I reckoned I would have made a good night watchman! I could feel my heart beating quickly as I lay there, trying to relax and get some sleep. Somehow I would have to drag myself through the

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<sup>7</sup> 'EO' or ethinyloestadiol is a form of HRT.

<sup>8</sup> An anxiolytic muscle relaxant more commonly known as 'Valium'.

day. Sometimes I felt OK, other times I felt a bit tired in the afternoon, hoping to get a full night's sleep that night, but the pattern would repeat itself.

So as not to disturb my husband (or have his seemingly amplified breathing disturb me) I would pack myself off to the spare bedroom - where I seem to have spent the last few months! In November, with my new doctor's consent, I went up to two tablets daily and then three in quick succession. I might add that I was taking these in the morning, a seemingly unimportant factor until the increased dosage hit my bloodstream approximately two hours after taking them and all the exhaustion I had been keeping at bay hit me like a ton of bricks. I had to come home from work one day. I was on the verge of physical collapse. I have never felt so exhausted in all my life. Since then I have read somewhere that it is sometimes advisable to take these tablets at night so as to tone down, if not avoid, possible side-effects. However, at night, no matter how tired I was, I would fall asleep and about an hour or two later I was wide awake again. Just before Christmas [three weeks ago] we wound the dosage up to three, then four, then finally five tablets and I started to take them at night instead. For the first few days my body would seem to respond and I would get a full night's sleep, then the pattern would begin again and we would have to increase the dosage.

I know that five 'EO' tablets is really the maximum before you begin to get side-effects and the liver is at risk and now I have begun to get sore breasts which I wasn't getting before. My doctor has switched me over to 'Premarin', and I took the first one last night. I had a good sleep until 4am, woke briefly and went back to sleep until 7am. I am hopeful this will relieve the problem as I know 'Premarin' has a good reputation.

As my doctor confirmed I am going through menopause, I got a number of books from the library and read up about what is actually happening to me. Not having any periods, of course, made it all a little harder to zero in on, but certainly the above symptoms seemed to confirm what I know now to be happening. I had a fair idea but wanted to know if my insomnia and night sweats were in actual fact part of [menopause].

I have discussed menopause with my mother. In her day there was no assistance whatsoever. She never had a hysterectomy but went through menopause at the age of forty-two and was finished (she feels) by about forty-five. She apparently also had insomnia which the doctor gave her some tranquillisers for. As she was a housewife, it wasn't quite so vital that she missed her sleep. She could sleep in, in the morning or catch a nap during the day if she needed it.

Menopause seems unfortunately to be a taboo subject with women as well as men. I am afraid I am up front about it. If I am having a flush, I say so. If someone else is embarrassed about me saying that, then that is their problem, not mine. When you are pregnant you can announce that you can feel the baby move or are suffering from morning sickness and it is socially acceptable, but for some unknown reason menopause does not appear to be a subject you are supposed to discuss in public or in front of men. The attitude appears to be that there is 'something wrong with her', 'she must be going through 'the change'' and I feel that it is well overdue for that attitude to change. The few women I know who are going through it whisper quietly together. A number of my friends who have yet to attain this stage don't really want to know. I feel that perhaps they don't want to face it because it is a bit like admitting you are getting old, but I still maintain [that] age is merely a state of mind. I feel there should be far more information readily available.

I believe that HRT is very important. There are some women who feel that HRT is something that male doctors try to force onto female patients in some show of male dominance. To that I say, 'Garbage!' Would they say that to a male doctor who was giving them a blood transfusion after a severe loss of blood or [to] a diabetic receiving insulin? Of course not. The principle is just the same. You are merely replacing something which your body is no longer able to supply, and the fact that it relieves so many symptoms (plus keeping bones and hearts strong) must be in its favour.

How do I feel about my experience of menopause? It sucks. I can't wait for it to be over and then I can begin to live again. I can handle getting older. I just can't handle my body being out of control and betraying me, this affecting my lifestyle. In short - I

just don't have time for all this physical rubbish and I wish it would hurry up and get it over and done with so I can get on with my life.

### **Gay**

*Aged 43, Gay is a New Zealand Woman's Day respondent who lives in Tuakau. She wrote, 'I trust that this epistle is of some help towards your thesis. Feel free to use what you wish from it'.*

I am forty-three years of age [and] have been married for twenty-four years to a wonderful man who is the Deputy Principal at the local area school. We have four sons whose ages [range between] twenty-one and [twenty-] nine. I am currently employed in middle management as a supervisor at a transport depot, a position I have held for two years now.

At the present moment I am knowingly nearly two years into menopause. For me this began in February 1994, and probably before then. I was at work when I got this tingling feeling which began in my feet and travelled up my body to my head making me feel extremely sweaty, hot and flushed. This was so real that I got up and went to the 'Ladies' and looked in the mirror, whereupon I discovered I was not flushed but was sweating. This occurred for a couple of days and then I got my period. In March it happened again, and so I rang my doctor's and suggested I might have begun menopause. He said, 'No, you're too young'. It occurred again in April and in May. It was a most peculiar feeling and I still believed I had begun menopause.

On the night of June 14, I was in a deep sleep and was woken with a sharp stabbing pain in my abdomen. I was extremely tired and thought, 'Gosh, that's not nice' and promptly went back to sleep. It happened two or three more times. Come the morning I went to work as usual and by lunch time had experienced quite a bit more pain (by this time it was intermittent and not long lasting. Sharp, stabbing and gone). I rang my doctor...and when I explained everything he wanted me there straight away. I was there by 3.00pm seen and was at hospital by 4.30pm. [I]t was decided I might have an ovarian cyst and not appendicitis, as first thought. At 11.00pm I was admitted to a ward...On the Thursday and Friday I was examined [but] the pain never got worse but didn't go away. Then they sent me for a scan. Upon the image being shown on the

screen the doctors could immediately tell what the problem was. My right ovary had a cyst inside which had stretched the ovary to the size of 5cm (which apparently is small) but the blood had leaked through the wall of the ovary into the peritoneum.

The surgeon discussed procedures with me and when I asked him to remove everything as I had no need for it any more, he refused saying that if he did that it may cause premature menopause. Whereupon I informed him that I was convinced I had already begun. He also said I was too young! In the operation my right ovary and fallopian tube were removed. After the operation I was removed from surgical to gynaecological ward where I was seen on a daily basis by a young doctor who appeared happy with progress but had no answer to my hot flushes and tingling which had started again after the operation. On the ninth day in hospital a gynaecologist came into the ward and wanted to know what I was doing there after nine days. The young woman doctor explained things and then he asked me what was going on. So I explained everything from February and was informed that I had indeed started menopause and that I should start taking HRT. He explained to me the importance of taking pills, as it could help with the hot flushes, sweats, dry vagina (which I had been experiencing for three to four years) and migraine headaches. Being totally uninformed about HRT, apart from what [the gynaecologist] had told me, I went onto it. My view [of] HRT [is] only that it has helped me and for that I am grateful.

I still have pain at ovulation and immediately (twenty-four hours) before my periods start. The hot flushes and sweats have disappeared. My vaginal dryness has improved in that at some stages we no longer need to use a lubricant. My migraines have altered in that instead of being blinders and being ill, they are now just down one side of my head and that side of my face feels numb (like it does when a dentist's anaesthetic is wearing off) and I have a sore ear. This lasts for a day to a day and a half but still leaves me washed out for another twenty-four hours once it has gone. My periods still last for five days but the flow is very diminished and after two days [it] is really just a nuisance.

I thought menopause would not start until I was about fifty years of age. I knew it was sure to happen and [there] was something dubious about how it was going to affect

me. The only thing my mother ever said about menopause was that it happened to women when they reached fifty to fifty-five and they got cranky and had hot flushes. I didn't know what she was talking about until much later when a friend who is twenty years older than myself began menopause and talked with me about what was happening to her.

The only thing I am looking forward to is the end of my periods. I still really feel that I am unaware of some of the process of menopause. Some women do talk among themselves, and whilst I think that can be a good thing [it may also not be because] if someone has had bad experiences with menopause and shares that with friends [and] if the friends have no experience of menopause then it could make them anxious.

My husband and sons have always been very supportive throughout anything that has happened to me - periods - migraines - ovulation - and I have tried to explain to them what is happening to me. My wish is for our sons to grow up knowing about the things that occur in a woman throughout her life. Friends [and] women workmates also have been supportive, however the men differ in that some of the older ones (forty-five plus)...laugh at hot flushes and sweats. I believe the reason for this is ignorance. The younger men tend to be supportive and are more prepared to listen to an explanation of why one does not feel so good.

## Chapter 8

### Climacteric and Control

Menopause as a life event was recognized far back in history. Aristotle (384-322 BC) noted menstruation to cease at age 40 years, and references to the cessation of the age of fertility continue to pepper the literature over the next 2000 years. Climacteric appears to be of Greek derivation representing the word used for ladder or steps of a ladder (Utian, 1997:2-3).

For women, whether viewed as objects rather than subjects of knowledge or defined as the meeting point of nature and culture, scientific discourse has been especially crucial in constructing reality as something they can embody but not know.

(Jacobus et al., 1990:7).

The term climacteric or 'critical period in life' (Tulloch, 1994, 264) is commonly used in the literature in reference to menopause.<sup>1</sup> Climacteric implies crisis, upheaval, difficulty, uncertainty and even danger and so its application to menopause both signals and reflects a negative view of this event. In the preceding chapters, it has been shown that the perception of menopause as a health hazard is promoted through the deficiency disease model which links oestrogen decline with the risk of long-term degenerative diseases such as osteoporosis and coronary heart disease. Similarly, while common sense views of menopause as a normal, natural life-stage signal liberation from menstruation and childbearing, there is also a negative association of the 'change of life' with mental instability and health problems. Underlying each of these views is an emphasis on change, and it is this notion which sustains and perpetuates social recognition of menopause as a critical female life-stage - that is, a climacteric.

Coupled with the narratives of the sixteen women presented in Chapter 7, the age group focus of this chapter facilitates the convergence of earlier themes, ideas and arguments with the experience of the fifty-two women in the study who described themselves as 'in' or 'through' menopause. This chapter examines the expectations, experience and reflections of the four age groups classified as: the four women aged seventy and over; the nine women in their sixties; the twenty-three women in their fifties; and the sixteen women in their forties. Overall, the aim is to identify central

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<sup>1</sup> The term climacteric was never employed by the women in the study in reference to menopause. Some of the older women, however, did refer to this event as 'the change' or 'the change of life'.

aspects of the menopause experience of each age group and the differences that emerge between them. As part of this aim, the reader is reminded of the desirability of maintaining a holistic view of the experience of individual women. To this end, those women whose narratives are included in Chapter 7 are identified throughout this chapter with the symbol ‘†’ as follows: Marion\*†, Pamela†.

## **WOMEN AGED SEVENTY AND OVER**

The four women in this group were Mary\*†, Beth\*† and Joan\* from the Feilding-Manawatu district and Dulcie†, a *New Zealand Woman's Day (NZWD)* respondent, from Rotorua. Although the age range within the group was only ten years (i.e. from seventy-one to eighty-one years) their experience of the onset of menopause occurred over a period of seventeen years. Mary\*† indicated that she started menopause around 1963, Dulcie† in 1968, Joan\* in 1971, and Beth\*†, who went through a late menopause, in 1980.

### **Expectations**

Mary\*† and Joan\* held only vague memories. Mary\*† had not talked with her mother or others about this event nor had she felt the need to ‘read up’ on the subject. Similarly, Joan\* had little to say about either her expectations or experience although she did mention that her mother (still regularly menstruating when she died at age fifty-nine) had commented, ‘You might be like me’. Neither Beth\*† nor Dulcie† had discussed menopause with their mothers, and in common with Mary\*† and Joan\* assumed they would ‘just get on with it’. Indeed, the expectations of all four women were characterised by stoic attitudes which were a product of common sense knowledge and the related taboo surrounding menopause.<sup>2</sup>

### **The Onset of Menopause**

Mary\*† stressed that she was ‘too busy working on the farm at the time’ to remember much apart from her age when her periods stopped. Likewise, Joan’s\* memories were overshadowed by her activities as a nurse at Dannevirke hospital, which she used as the benchmark for her recollections. A ‘big bleed’ that continued for forty days

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<sup>2</sup> See Chapter 5.

towards the end of menstruation was recalled, together with an unrealised threat of surgical intervention and a weight gain which took 'years to get...off'. Dulcie† and Beth\*†, on the other hand, held clear memories of menstrual irregularities and accompanying tiredness, flushing and, in Beth's\*† case, depression, a lack of concentration and irritability.

### **Coping With Symptoms**

Although Mary\*† remembered the 'odd hot flush', her comments suggest that a stoic attitude and hard work diminished their impact. Joan\* did not recall any symptoms at all and remarked she 'didn't have any trouble'. In contrast, the narratives of Dulcie† and Beth\*† provide accounts of ongoing and distressing symptoms. Beth\*† describes how her symptoms were compounded by periods of depression, difficult and stressful personal circumstances and pressure from the expectation that 'you [would]...be able to cope'. When feeling particularly unwell she found reassurance in books which indicated that 'these things were to be expected in the menopause by some women' even though such knowledge did little to relieve her discomfort. Eventually she sought the help of her doctor, noting that by that stage she 'didn't care' as she 'had to have help'. Indeed, Beth's\*† narrative reveals that the medical context provided her with a legitimate space for her to discuss menopause without fear of social sanction or censure. As a result, Beth\*† was the only one of the four to receive treatment with HRT. Finally, Dulcie† described how the severity and duration of her hot flushes left her feeling nearly 'suicidal'. Her regret at not being offered HRT by any of her doctors suggests that she had little choice but to endure her symptoms for a period of sixteen years. The difference in medical treatment offered to Beth\*† and Dulcie†, can be explained by the fact that Beth\*† experienced a late menopause onset in 1980, whereas Dulcie† placed the onset of menopause at around 1968. In the late 1960s, HRT treatment was not commonplace in New Zealand unless a woman had undergone a total hysterectomy (see 'Women in Their Sixties' later in this chapter).

### **Reflections**

Mary\*† and Joan's\* reflections were characterised by ambivalence, stoicism and taboo. Although Joan\* had little to say about her experience, apart from feeling she

'just sailed through it', she did comment on a friend who (like Dulcie† and Beth\*†) experienced problems with symptoms:

I had a girl friend that I used to work with and she was always having these hot flushes and the doctors were always giving her [tranquillisers] to quieten her down.... 'Just women's trouble', that's what they used to refer to them [as], 'women's trouble'. Nothing was done. There was no scientific things in those days. I think people are a lot luckier today.

The view of menopause as a negative event marked by stressful personal circumstances and health problems dominated the reflections of Beth\*† and Dulcie†. Both perceived a lack of understanding and sympathy from their husbands and friends. Beth\*†, for example, recalled occasions when she felt 'ostracised' as a result of others perceiving her to be 'in one of her moods'. She was embarrassed when she went 'all red' during a hot flush and concerned that other people would notice the beads of perspiration on her forehead. She also commented on how her husband attributed all her feelings and reactions to 'the change' when in fact she felt they were also associated with (and at times originated from) her difficult personal circumstances. Dulcie's† desperation over the 'bad effects from menopause' is evident in her comment that she became 'almost suicidal'.

The difficulties experienced by Beth\*† and Dulcie† were compounded by the social expectation of stoic endurance, a product of the climate of taboo and associated sanctions, which prevented them from talking with other women. 'You didn't talk about that sort of thing...you were supposed to be able to cope', said Beth\*†, while Dulcie† noted that the subject was 'never, ever' discussed among the various groups of women that she mixed with. It is therefore not surprising that neither woman had access to common sense strategies for coping with symptoms (aside from hard work) and that both felt socially isolated and misunderstood. The severity of their symptoms, moreover, limited their ability to 'just get on with it' and so put them at risk of being perceived as socially deviant (e.g. when Beth\*† was perceived to be 'in one of her moods'). Moreover, in attributing everything to 'the change', Beth's\*† husband undermined her ability to resist or transform events outside the menopausal frame. The point is that once her feelings and experiences were labelled as menopausal in origin, she was unable to share them with others because of the taboo and the social

requirement of stoicism. She had little option, therefore, but to cope with things as best she could.

### **Commentary**

The experiences of the seventy and over age group were dominated by the taboo on menopause and the social requirement of stoicism. Indeed, their reflections confirm Sheehy's (1993:29) claim that older women 'educated before the sexual revolution' belong to the 'silent generation...[who] have never been comfortable about sexual matters'. More importantly, their taboo generated silence, stoicism, guilt over needing help, embarrassment at the visibility of symptoms and feelings of isolation all point to control of the body as the central aspect of their menopause experience.

Turner (1991:85) argues that 'throughout history women's bodies have been treated as especially threatening to the moral and social stability of society'. The view of women as irrational, morally weak and sexual temptresses has its origins in the description of the fall of Eve in Genesis. Such a view was strikingly evident during the fifteenth and sixteenth centuries when an obsessive fear of female sexuality was fuelled by the belief that: 'The Devil was...loose...and was working in his traditional way through that weaker, more susceptible half of mankind, womankind' (Easlea, 1980:2). Old, helpless and poor peasant women in particular, living 'beyond the immediate control of men', became the target and fatal victims of witch hunts (Easlea, 1980:33).<sup>3</sup> Despite the shift in emphasis from the moral to the physiological aspects of female sexuality during the Enlightenment, the need to control women's bodies persisted.

A medical focus on female reproductive organs as the essence of femininity underpinned Victorian recognition of the uterus as the regulator of a woman's

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<sup>3</sup> There is a considerable body of literature on the subject of witches which, although it presents a variety of explanations of this phenomenon, is beyond the scope of this thesis. Easlea (1980), for example, also points out that in addition to a fear of the sexuality of witches, the state of poverty of many older women living on their own meant they made demands on the community for their survival. This situation was frequently resented and so made such women vulnerable to accusations of witchcraft.

personality, abilities, limitations and social role (Barbre, 1993:26).<sup>4</sup> Indeed, medical identification of women as creatures driven by the uterus, associated with hysteria since the time of the Greeks, affirmed the received wisdom of female moral and physical fragility and inferiority.<sup>5</sup> Medical treatment such as rest cures were overlaid with paternalism and moralism and expressly targeted those who, like the victims of witch craze, appeared to threaten the conventions of 'normal' society. In Victorian society, upper- and middle-class young single women, widows and older women, and divorced or spinster females, that is those living outside the influence of a patriarchal relationship, were viewed as potentially threatening to the conventions of marriage and normal sexuality (Turner, 1991: 89).

The onset of menopause offered Victorian women the prospect of liberation from lifestyle restrictions designed to protect their reproductive organs.<sup>6</sup> Counteracting such a promise, however, was the view of menopause as a signal of old age, 'the gateway...through which a woman passed at the peril of her life' and the associated risk of moral insanity (Sheehy, 1993:31). Free from the duty and demands of childbearing, the older woman was believed to present a renewed threat to the social order through urges such as the desire to shoplift and surges in sexual activity (Barbre, 1993:28).<sup>7</sup> Post-menopausal women were accordingly urged to devote the remainder of their lives to domesticity and seclusion and to 'concentrate on their role as moral guardians' (Barbre, 1993:30).

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<sup>4</sup> Ehrenreich and English (1987: 108), for example, cite the views of Professor M. L. Holbrook who, when addressing a medical society in 1870, observed that it seemed 'as if the Almighty, in creating the female sex, had taken the uterus and built up a woman around it'. Barbre (1993:26) also points out that 'Employment; social activism; contraception; excess in food, dress, or sexuality; novel reading; and education were all activities [which were viewed as likely to] over-stimulate a woman's nervous system and thus endanger her reproductive system.'

<sup>5</sup> The term 'hysteria' comes from the Greek 'hystera' or womb.

<sup>6</sup> There was, for example, the perception of the brain and reproductive organs competing, like a mini economic system, for the body's resources. As a result women were urged to 'throw their weight behind the uterus and resist the temptations of the brain. Because reproduction was women's grand purpose in life, doctors agreed that women had to concentrate all their energy downward towards the womb' (Ehrenreich and English, 1978:114).

<sup>7</sup> Greer (1992:321) argues that the 'notion that menopause often brings a surge in women's sexual urges dies hard. Its origins are lost in the annals of prejudice. In *The Spectator* No. 89, Joseph Addison, counselling women against 'the folly of Demurrage', warned them darkly about the craziness that lay in wait: '...there is a kind of *latter Spring* which gets into the Blood of an Old Woman, and turns her into a very odd sort of Animal...'

The influence of Victorian attitudes to female sexuality is evident in the perceptions and comments of Mary\*†, Joan\*, Dulcie† and Beth\*†. Although all were born a decade or two after the turn of the century, they were raised (socialised) by Victorian-born parents. While the precise origins of the taboo surrounding menopause remain obscure, their reports of maternal reticence and the reluctance of peers to discuss any aspect of female reproductive functioning is indicative of the persistence of assumed Victorian notions of indelicacy.<sup>8</sup>

Associated with the climate of taboo was the expectation of a stoic demeanour. In this climate the sharing of common sense knowledge has been constrained and it is possible that women will attribute menopause-generated symptoms to other factors - they may also do this even when they suspect otherwise because they are aware of the possible sanctions. The fact that all the women expected to 'just get on with it', and that Dulcie† and Beth\*† felt isolated and misunderstood when they did experience severe symptoms, is commensurate with such a suggestion. The implication, therefore, is that the notion of menopause as an illness simply did not arise in the context of what was defined as an uneventful transition marked only by the end of menstruation. It was not surprising that both the experience and inability to cope with symptoms was regarded as an indication of a lack of fortitude. Beth's\*† comment 'if you can't put up with it, you have got no backbone' is testament to this view and reflects a common sense understanding of women's reaction to menopause derived from essentialist assumptions about the nature of women as physically and morally (including psychologically) inferior and weak. Viewed in this way, the stoic endurance of symptoms constitutes both a resistance to essentialist views of womanhood, and an avoidance of being perceived as socially deviant.

Integral to the expectation of a stoic attitude was the belief in hard work as the antidote for mid-life health problems. Again, the implication is that menopausal

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<sup>8</sup> While the citizens of New Zealand appeared to have considered sexuality and female reproductive functioning a taboo subject for discussion, recent research on Victorian England by Barret-Ducrocq (1991:2) indicates that alongside an 'undeniable modesty in matters of speech, gestures and clothing, there [was] at all times a public, respectable discussion on sexuality, an explicit and prolix discourse from which sexual enjoyment is absent, erotic excitement perhaps less so'. In New Zealand, however, as Hercock (1991:182) indicates in relation to attempts to introduce birth control measures as late as the 1930s, 'Sexuality was regarded as an intensely private matter by respectable society'.

difficulties result from personal shortcomings. Underpinning the emphasis on hard work were two factors: first, the fear of going mad - a perception confirmed by whispered comments about women 'loosing it' or entering mental institutions, comments which reflected unchanged essentialist arguments associated with the Victorian fear of moral insanity at menopause (see Barbre, 1993:29-31);<sup>9</sup> and second, the legacy of the colonial role and status of New Zealand women. Coney (1995:6) points out that among the European settlers marriage was primarily an economic arrangement with the role of the woman being that of 'a proficient 'helpmeet' [sic, helpmate?] to organise the home'. In other words, colonial women played a pivotal economic as well as moral role with the former frequently involving 'heavy lifting [and] long hours...in addition to outdoor work' (Brookes, 1991:151). Under such conditions most women had no choice but to 'keep going', and in so doing created a tradition of stoic endurance and hard work. Mary\*†, a farmer's wife, appears to fit the mould particularly well.

The dependence of female status and worth on marriage and motherhood, that dominated Victorian and (until the 1960s) New Zealand society, also ensured the perpetuation of a tradition of hard work and stoicism.<sup>10</sup> Reflecting the view of the woman as the protector and promoter of family moral and physical well-being, the role of the New Zealand wife and mother has traditionally demanded self-effacement and sacrifice. The following advice, which appeared in a series in the *New Zealand Woman's Weekly* in the mid-1950s (Solon, 1957a:8; 1957c:15), provides more recent evidence of the social expectations of the role of women<sup>11</sup>:

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<sup>9</sup> Citing Tilt (1992:101), Barbre (1993:29) notes that moral insanity 'could cause normally moral women to act without principle...be untruthful...peevish...steal...leave their families...brood in melancholy self absorption'. Chapter 5 identifies the perception among older women in the study that menopause was a time of risk from mental instability. See also Formanek (1990:12-14).

<sup>10</sup> See Chapter 6. Kedgley (1996:26) points out that at the turn of the century and for some years later unmarried and single mothers were considered immoral and that mothers who were married were looked upon as the moral guardians of the home and family and considered to be morally superior to men. See also Ebbett (1981:36) who points out that in the 1930s, New Zealand girls often had great difficulty acquiring education, finished schooling at age thirteen and it was generally understood in many families that daughters would not go on to high school. For those who went into teaching there was a contract requirement that they should quit upon marriage, a matter that gave rise to considerable argument (Ebbett, 1981:42).

<sup>11</sup> A time when Mary\*†, Joan\*, Beth\*† and Dulcie† would have been in their late thirties or early forties.

The young-looking face, whatever the age, is the face at peace, untroubled by emotions of hate, envy, anger, fear and aggression. No face looks old if you can read in it a story of love, gentleness and understanding.... There is no such thing as an ugly face in itself. There are faces which show bad... health, bad temper or bad luck. And all of these kinds of 'ugliness' can be largely corrected.

...women flourish in hardship because their roles as wives and mothers have become more important.

Overall, the women in the seventy and over age group viewed their experience of menopause with ambivalence or negativity. For these women, menopause was primarily a socially prescribed event constrained by normative definitions of the feminine. Accordingly, the women placed considerable emphasis on control of the menopausal body in order to avoid conforming to negative stereotypes which cast the mid-life, menopausal woman as neurotic, weak, deviant or mad. As part of the eclectic, disjointed and often contradictory mixture comprising common sense knowledge, it can be readily argued and accepted that these stereotypes played a major role in shaping the menopause expectations, perceptions and experiences of these women in a climate of taboo.

### **WOMEN IN THEIR SIXTIES**

Nine women were in their sixties. Of these, one (Sylvia, a *NZWD* respondent) was from Rotorua, while the remainder were from the Feilding-Manawatu district. Aside from Joyce\* (who experienced a surgical menopause at the age of twenty-five) and Noeline\* (who did not reach menopause until 1989), the onset of menopause for women in this age group occurred between 1970 and 1979.

### **Expectations**

In common with the seventy and over age group, the women in their sixties lacked medical knowledge of menopause and their expectations, influenced by the same negative stereotypes, were marked by the intention to 'just get on with it'. In some cases, early memories and/or later observations of the behaviour and attitudes of their mothers and other older women also influenced their expectations. Marion's\*† narrative, for example, attributes her view of menopause as a 'bogey' to childhood memories of the experiences of her mother and aunt, as well as the whispered comments of other women. Despite her fears, Marion's\*† narrative makes it clear that

she did not expect menopause to 'interfere with [her] life' and anticipated that she would 'just get on with it'. Similarly, Helen's\*† expectation was profoundly influenced by her mother's behaviour and view of menopause as 'a terrible time', as well as by a workmate's experience and reaction to the occurrence of hot flushes. Helen\*† was consequently determined to go through menopause as 'quietly and unobtrusively' as possible. Finally, although Jackie\*† did not anticipate any particular difficulties, her narrative associates her mother's refusal to discuss the subject and her own earlier disinterest with her lack of knowledge prior to the onset of menopause.

The remaining women (Betty\*, Joy\*, Norma\*, Noeline\*, and Sylvia) all indicated they knew little about menopause, and each commented on the refusal or reluctance of her mother to discuss and/or acknowledge it as a stage in one's life. Noeline\*, for example, had no memory of her mother's experience and found that whenever she broached the subject the response was always the same, 'There wasn't anything to it'. She concluded that her mother 'just got on with life' and Noeline\* expected to do the same. Betty\* admitted she would never have dreamed of raising such a topic. She explained:

I knew nothing about menopause. People didn't talk about it...my mother just didn't. I can't remember her having any symptoms, she certainly never talked about them. She had six children and worked very, very hard. In those days they just worked until they dropped and hard work seemed to keep them alive...they didn't talk about such things as menopause.

Sylvia wrote of a similar experience:

Menopause was never, ever mentioned by my mother or grandmother. One never spoke of such matters when I was young. When my own mother was menopausal I did not know about it at the time, but later when I realised what was wrong I was determined when my turn came I would not be like her.

Unlike Helen\*†, however, Sylvia did not specify what exactly shaped her resolve. In contrast with the other women, Joyce\* did remember her mother making the comment 'Well at the moment all I am getting is hot flushes...and I will be darned happy when it is finished!'. She reflected, however, that nothing further was ever mentioned and that her mother 'seemed to flow through it'.

### **The Onset of Menopause**

The combination of restricted memories of their mother's experience, lack of mother/daughter communication and obscure whispered comments meant that some of

the women were apprehensive about menopause and others were unsure of the signs of its onset. Marion\*† and Jackie\*†, for example, identified difficulties with flooding and erratic periods towards the end of menstruation. Clearly surprised by such changes, Jackie\*† sought information from her doctor about 'what was happening to [her] body', while Marion\*† described her horror at the return of her period on the day of her son's graduation. Both women remembered the inconvenience and embarrassment of flooding despite managing the problem in ways which caused minimal disruption to their lives. As Marion\*† explained, 'You put it to the back of your mind and get through it. It's amazing what you can get when you go looking.... The chemist store was very helpful'. Joy\* also referred to a couple of episodes of heavy bleeding in conjunction with erratic periods towards the end of menstruation but unlike Marion\*† and Jackie\*† had not found these experiences 'distressful at all'.

Helen\*† and Betty\* associated the onset of menopause with menstrual changes. In Betty's\* case these changes were accompanied by intermittent feelings of anxiety, 'a feeling of almost a slight panic'. Betty\* also recalled that when she requested information on menopause her doctor responded 'It doesn't exist. It's all in the mind.' A total hysterectomy meant that Joyce\* went through a different experience:

I had menopause forced upon me when I was twenty-five. I had to have everything removed - ovaries, fallopian tubes and the womb. I was all right one day and the next day...I started the hot flush and I was feeling so ill, it was like morning sickness!

Although Joyce\* found her doctor 'excellent and he sort of told me what I could expect', she also felt she 'didn't know much and it was virtually after [the surgery] that I found out all these things and I have been on HRT since'. Noeline\* had also undergone a hysterectomy while in her mid-forties. She commented that at the time she was given no information on what to expect at menopause and lacking the normal signs of menstrual change was unsure when her menopause began.

### **Coping With Symptoms**

The range of symptoms attributed to menopause, their degree of severity and strategies for coping varied among the women. Without exception all referred to the occurrence of hot flushes, which were usually accompanied by night sweats. Marion\*† commented on the transitory nature of her hot flushes, an accompanying 'sudden feeling of a great whirl in side you', and noted that they 'can still occur'. She discovered that limiting her

intake of bananas, tea and coffee helped keep them under control. Helen\*† recalled suddenly feeling hot and, determined not to draw attention to herself, would just ‘quietly stand up’ or move around in her chair waiting for the flush to pass. Unlike some of the others, Helen’s\*† experience of hot flushes was short-lived and during this period she used a ‘time factor’ to help herself through:

...from what I had read, from when the [last] period stopped...it had to be stopped two complete years...and then you were classified as being through the menopause. So that’s what I went by. ‘Two years’, I told myself, ‘two years!’

In common with Marion\*†, both Jackie\*† and Norma\* also continued to experience hot flushes. Jackie\*† described how her flushes evolved into ‘warm’ sensations of heat creeping up her arms and from the middle of her abdomen, whereas Norma\* described them as ‘literally...start[ing] at your feet. You can feel them go all the way up and you go like a beetroot’. In common with Marion\*†, Jackie\*† linked the occurrence of hot flushes and night sweats with certain foods and therefore modified her diet. She also found exercise beneficial and adopted a strategy of being very open with others about what was occurring, except when with her mother.

The unanticipated onset and severity of night sweats was a feature of Marion’s\*† experience. She reflected, for example, how she would suddenly be ‘awake in a lather of perspiration’ and want to throw all her clothes off. Helen’s\*† experience of night sweats was similar. In hindsight she was amazed at her ability to sleep through a cold winter with minimal bedding, something she admitted she had never done ‘before or since’. Jackie\*† also experienced severe night sweats which left her ‘woozy’ and needing a supplement to restore her body’s electrolyte balance. Not surprisingly, all three women remembered feeling tired around this time.

Tiredness associated with ‘hot flushes at night’ was also experienced by Sylvia and Noeline\*. Although Noeline\* did not consider her night sweats ‘as bad as others’, she:

...didn’t get enough sleep. I was working at the time [and as a result] the old blood pressure went up and so I have been on HRT [since]...whenever I try and get off the HRT my sleep pattern is altered...and up goes the blood pressure so I am caught...

Betty\* also experienced night sweats but, unlike the other women, had not found them to be a problem:

Some friends...have got to get out of bed and change their nighties, sheets, everything. I was waiting for [that] to happen [but] that never happened to me. It would just be for a few seconds and I would put my feet out the side of the bed and then it would be gone.

Feelings of being 'up tight' and 'anxious' were reported by Helen\*† and Betty\*. Helen\*† associated 'being up tight' with the occurrence of flushes around the time menstruation ceased. In Betty's\* case, 'anxiety attacks' and some depression occurred prior to and around the time she went through menopause. Her family doctor prescribed 'Librium' and 'Valium', which she was reluctant to take. Indeed, she commented that she accumulated 'a teapot full of them...[as] they used to dish them out like lollies!' As it turned out, the most effective strategy for coping with her symptoms proved to be finding a job:

...at about forty-nine my periods had gradually trickled away and then stopped...I would get depressed at times...Luckily I went to work and worked ten years. That helped me through, ...I always say that saved my sanity...had I not being working I think I would have felt sorry for myself and the problems would have been worse because I would have had time on my hands.

In all, four of the women (Joyce\*, Noeline\*, Sylvia and Norma\*) were being treated with HRT for the relief of ongoing symptoms at the time of the interview. Joyce\* had been taking replacement oestrogen since her surgery, thirty-nine years earlier, and was resigned to the medical opinion that she would be on HRT for life. 'If I could do without [it] I would. I even tried it actually [but]...within three days I start [to feel nauseous and have hot flushes]'. Noeline's\* attempts to wean herself off HRT had also been unsuccessful, and she commented:

...the doctor tells you that it is quite safe for people who have problems with blood pressure and heart conditions [but] I feel as though seven years is long enough. It seems that when you try to get off that pill you are going through the menopause - you know this hot flush business all over again!

Ironically, Noeline\* had initially been discouraged by her doctor from taking HRT:

...because I had a blood pressure problem and it was only through some reading I had done that I found it was okay for me to have it. The doctor thought I was high risk for cardiac problems and he wouldn't let me have [HRT] for quite a long time. [His attitude was] just grit your teeth and bear it, pull yourself together.

Sylvia wrote that she was 'still on oestrogen' but had discontinued the use of vaginal cream after her husband died as the 'treatment did not make any real improvement'. Betty\* also mentioned vaginal problems but discontinued the treatment with oestrogen pessaries after a few days because it aggravated her vascular problems.

## Reflections

Reflecting on their experience, the women in their sixties generally viewed menopause as a positive, natural life-stage. The worst fears of some were not realised and although Marion, for example, found menopause 'never ending at the time', it was not 'anywhere near the thing it was made out to be'. Marion's\*† narrative makes it clear that she was 'too busy doing other things' to worry about menopause and was a firm believer in not allowing such events to 'rule your life'. Her comments about her sister having 'always been a plague to all these problems' provide further evidence of her attitude, and suggest a conviction similar to that held by Betty's\* doctor, namely that menopause was 'all in the mind'. On reflection, however, Marion\*† did feel that life was easier now that she was through menopause as she felt 'healthier and stronger' than before.

Helen's\*† comment that she 'might have been one of the lucky ones' also suggests her experience of menopause was less difficult than anticipated, although like Marion\*† she was determined not to let it interfere with her life. In common with a number of the others, Helen\*† was convinced that being in the paid workforce was of great benefit to her at this time. Joy\* remarked that she 'didn't think [she] had a very interesting menopause' and found it difficult to separate her experience from other events in her life. Like Betty\* she felt that 'maybe if I had just been stuck at home I might have [dwelt on it] but I was learning a new job and meeting new people and getting other interests as well'. Noeline\*, who worked as a nurse two or three times a week during much of this period, argued that menopause was something 'you just have to take in your stride. I just had to be sure that I didn't over tax myself with things at home so that I could be ready for work'. Sylvia was also adamant that menopause is 'a normal part of life' and she, her friends and workmates just 'got on with it'.

Several of the women reflected on the emotional changes they experienced during menopause and their desire for affection from husbands and support from friends. In light of her own experience, Norma\* thought that:

...women at a certain age are very emotional...and I think when you are going through menopause you are fighting a losing battle until in the end you get to break points where it all comes out.

Her observation was shared by Sylvia, who as a former practice nurse remembered that:

When myself and the general practitioners were working together and had pre-menopausal patients who were 'emotional' people, we hoped we wouldn't have them as patients when they were at menopause as they would dramatise so much!

Helen\*† noted her desire for affection and the 'boost' obtained from a kind remark or compliment. She also mentioned the benefit of working with 'other women going through the same' and the difficulty of being unable to share or discuss her feelings with her unsympathetic husband. Sylvia's comment that her husband (since deceased) did not 'want to know about female health', suggests a similar experience. The remaining women, however, aside from Joy\* who was widowed, all commented on and were appreciative of the support and understanding they received from their husbands.

### **Commentary**

In contrast with the older group, those in their sixties held clearer recollections of menopause and were more forthcoming and detailed about their experiences. The most important feature of their experiences, however, was that they too were influenced by the climate of taboo (albeit in a somewhat weaker form) and ethic of stoicism. As a result their ability to communicate openly about menopause in a number of social settings was still restricted and they therefore lacked the opportunity to readily and effectively challenge common sense notions. Ultimately this contributed to their apprehension and uncertainty over the onset of menopause even though they had garnered from various sources knowledge of strategies for the management of symptoms such as the time-honoured and 'proven' techniques of hard work and keeping their minds occupied so that they would not 'dwell on' their problems. And, when all else failed, medical management with antidepressants for a problem often regarded by themselves and members the medical profession as a product of the mind.

The continuation of the taboo was most apparent among the women's mothers, with only one mentioning the subject with her daughter. There were, however, signs that the taboo was beginning to break down. As a group, these women were less inhibited than the older women about seeking information once they realised they had reached menopause. Although some (such as Marion\*†) found their peers unwilling to discuss

the subject, it was clear that this was not always the case. Helen's\*† comment, for example, on the benefit of working with other women 'going through the same' suggests that some sharing of experiences occurred. Moreover, a number indicated that they felt quite comfortable discussing menopause with younger women. Overall, however, the women in the sixties age group were limited in their ability to openly communicate about menopause. As a result they lacked the opportunity and means with which to effectively challenge negative stereotypes that were part of their common sense knowledge and so allay their fears, apprehensions or uncertainties about the onset of this event.

Their expectation that at menopause they would 'just get on with it', like their attitudes toward the behaviour of others, exemplified the ethic of stoicism and marked the presence of taboo identified among the seventy and over age group. Marion's\*† comment on her sister ('always been a plague to all these problems') and Sylvia's view of 'emotional' patients, for example, illustrate that failure to stoically endure symptoms continued to place women at risk of social disdain. Moreover, a belief in hard work as the antidote for mid-life health problems persisted, as was evident in the remarks of Betty\*, Joy\*, Helen\*† and Noeline\*, all of whom felt that having a job meant that you were too busy to dwell on the discomfort of symptoms. Such an attitude reflected the endurance of some long-standing common sense and medical assumptions that menopause-related difficulties were 'old wives tales' and by implication a product of the mind.<sup>12</sup>

The symptoms they associated with menopause were similar to those identified by the older age group, and in keeping with tradition Betty\*, Helen\*†, Jackie\*†, Joy\* and Marion\*† relied primarily on a stoic attitude and hard work to exercise control over their symptoms. Jackie\*† and Marion\*† also modified their diets and, in Jackie's\*† case, an exercise strategy was adopted. Only Helen\*† employed a 'mental' technique to help her through. In view of the restricted recollections of the older women, however, it was not clear whether the diet modification and exercise strategies were either innovative or 'tried and true' approaches to the management of symptoms nor

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<sup>12</sup> See, for example, the comments of Betty's\* doctor in Chapter 5.

whether all management strategies employed were in fact identified. Nevertheless, one distinctive feature of symptom management in this group was the number of women being treated with HRT. Aside from Joyce\*, who must be regarded as a special case, three of the nine women were taking HRT.

The fact that one third of this group were on HRT for the control of symptoms can be accounted for by a change in medical knowledge and attitudes between the early 1960s and mid-1970s. In contrast with Betty\*, who started menopause in 1971 and was prescribed 'Librium' and 'Valium' when she consulted her doctor, none of the three on HRT reached menopause until the late 1970s. Indeed, the experiences of those in the seventy and over age group confirm a similar pattern. Joan\* (who reached menopause in 1971) commented 'There was no scientific things in those days', while Dulcie† (who reached menopause in 1968) expressed her 'grief' at not being offered HRT. The only one from the seventy and over age group to receive HRT was Beth\*†, who reached menopause in 1980.

As discussed earlier, Wilson's promotion of oestrogen in the mid-1960s signalled a new era in medical attitudes towards menopause and its treatment. Prior to Wilson's 'discovery' of the benefits of oestrogen in offsetting the impact of menopause, those women unfortunate enough to experience severe difficulties were commonly viewed as hypochondriacs, mentally unstable or (as identified by the women in this study) lacking in moral fibre. Indeed, Coney (1993:56-57) draws attention to the widespread use of tranquillisers and anti-depressants among mid-life women of the 1950s and 1960s, noting that:

...medical journals in the 1960s are littered with advertisements for products such as 'Valium', 'Librium' and 'Amitriptyline' for which the principal target was women...they were widely promoted to doctors as being ideal for middle-aged women and able to 'cure' the symptoms of menopause.

Describing the 'consumer campaigns' associated with Wilson's promotion of oestrogen replacement therapy, Coney (1993:157) points out that over the ten year period 1963 to 1973 the 'dollar sales of oestrogen quadrupled in America'. She also points out that use of HRT was slower to take off in Britain where the number of prescriptions more than doubled between 1972 and 1976 (Coney, 1993:162). While Coney does not pinpoint when the use of HRT 'took off' in New Zealand, it seems

reasonable to assume (in the light of overseas trends) that hormone treatment would have become readily available by the mid to late 1970s.<sup>13</sup> Certainly by the late 1980s the pharmaceutical companies were (Coney, 1993: 177):

...active [in]...promoting the benefits of their wonder hormones. During 1989, Ciba-Giegy sponsored symposia on the management of menopause for general practitioners...[and] the *New Zealand Doctor* published a supplement on menopause in 1990. The emphasis is on education about 'the problem'...rather than the drug. Doctors are relied upon to make the transition from identification of the problem to use of the product....women [are invited] to 'talk with their doctors' [about their symptoms].

The emergence of HRT use as a strategy for controlling menopause-related symptoms among the women in their sixties has a number of implications. First, as a significant new ingredient in the evolving pot-pourri of common sense knowledge, it presented a challenge to the ethic of stoicism. The point here is that medical redefinition of menopause as a process of hormonal decline legitimised the experience of symptoms that could no longer be dismissed as 'a product of the mind' or a lack of moral fibre. Second, the treatment of menopause with HRT opened the door for the shift from the popular view of menopause as a natural life-stage associated with some discomfort, to one of a physiological event accompanied by medically identified symptoms. At issue here is an altered popular perception of the process of menopause that is accompanied by new attitudes towards and expectations of this event. Third, publicity associated with the promotion of HRT placed the subject of menopause in the public arena. The resultant public interest and discussion further eroded the taboo surrounding menopause while at the same time fostering medically orientated common sense perceptions of this event. Fourth, there was and there still is a risk that as stoic management is replaced by medical management, perceptions of menopause will swing from one extreme to another. That is, swing from a refusal to acknowledge that *some women experience* severe symptoms at menopause to a refusal to acknowledge that

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<sup>13</sup> Coney's (1993) comprehensive examination and critique of the development, impact and implications of HRT makes her an authoritative source on the subject within the New Zealand context. The fact that she does not provide figures on the historical rates of use of HRT in this country or pinpoint the date at which treatment with this drug became commonplace, suggests that such information is unavailable. The Replay Radio programme (discussed in Chapter 3), originally broadcast in 1982, supports the assumption that HRT had become readily available in New Zealand by the mid to late 1970s. In particular, the edited version of the 'talk-back' section of the broadcast on the reverse side of the tape presents the experiences of a number of women who had been taking HRT for some years.

*many women do not experience* severe symptoms at menopause. As Morse (1997: 55) points out:

For many women, the experience [of menopause] is minimal with transient effects, if any; for others it heralds the onset of significant ill health with long-term adverse outcomes. It is clear that a biological hormonal explanation alone cannot account adequately for all the wide range of symptoms that women report.

In short, there is a high risk of medicalisation of menopause through the promotion and use of HRT as a management strategy for associated symptoms.

Finally, it should also be acknowledged here that there is the problem of a backlash to the medicalisation of menopause through the promotion of HRT. There is a tendency among some women's health advocates such as Coney (1993), for example, to view the promotion of HRT as form of patriarchal control over women's bodies. Although dismissed by some women,<sup>14</sup> Coney's view is embraced by others and advances a new orthodoxy. Just as women in the past who articulated their problems were perceived as neurotic, moaners and/or lacking in moral fibre, those who currently seek HRT are seen as weak and unable to control their bodies as well as being manipulated by the medical profession. Consequently, those who have problems continue to be condemned and judged for conforming to and perpetuating essentialist notions of female physiological and psychological inferiority and deviance. Moreover, attempts by women's health advocates to promote menopause as a time of positive changes and new-found freedom compounds the situation. Lacking the necessary health or stamina to 'climb mountains' or seek new challenges, women experiencing problems are judged to have something wrong with them. Conversely, if they seek to treat the problem, in order to 'climb mountains' or take advantage of their new-found freedom, they are perceived as weak and unable to control their bodies.

## **WOMEN IN THEIR FIFTIES**

The largest group of women who identified themselves as 'in' or 'through' menopause were the twenty-three aged in their fifties. Ten of the women were from the Feilding-Manawatu district area, while the remainder were *NZWD* respondents who lived in

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<sup>14</sup> See, for example, the discussion of 'HRT' in Chapter 6. Among the supporters of HRT was Sue Pt who said, 'There are a few women who feel that HRT is something that male doctors try to force onto female patients in some show of male dominance. To that I say, 'Garbage'!'

Auckland (Beverley†, Marilyn†, Moira, Sally and Zelda), Hokitika (Colleen), Upper Hutt (Helen), Taupo (Jan), Nelson (Merle and Mariet†), Christchurch (Margaret), Taranaki (Pamela†) and Wellington (Pat). Among all the women in this group: Marilyn† and Bella\* had undergone a surgical menopause in 1975 and 1978, respectively; Colleen\* experienced the onset of menopause around 1977; Jan, Jacky\*, Merle and Pamela† all identified the onset as occurring between the mid and late 1980s; and the remaining sixteen women did not reach this life-stage until the 1990s.

### **Expectations**

The narratives of Barbara\*†, Beverley†, Mariet†, Marilyn† and Pamela† identify a range of menopause expectations typical of the women in this age group. Both Barbara\*† and Beverley† looked forward to the end of menstruation and neither expected to encounter difficulties with symptoms. Barbara\*† did not actively seek information on menopause nor did she find it a subject discussed openly by her friends. Instead, her expectations were shaped by memories of her mother's experience of menopause as 'a breeze' and her grandmother's view of hot flushes as 'worth their weight in gold'. Having followed her mother's menstrual pattern, she anticipated her menopause would take a similar course and was resolved to 'just go along with it'. Beverley† had never discussed the subject with her mother but was able to do so openly with friends. She looked forward to menopause as a welcome release from the inconvenience and expense of menstruation, and firmly believed that a positive mental attitude would keep difficulties at bay. In this respect, Beverley† was articulating a coping strategy adopted by the older women, a strategy that was part of the ethic of stoicism.

Mariet† felt that 'women talk about menopause more in the nineties' but admitted she had dreaded this event after 'hearing other people's stories'. She had not talked with her mother before she reached menopause as, unlike herself, her mother had undergone a hysterectomy. It was not clear whether Marilyn† had talked with her mother but she indicated that she 'certainly [did so] with [her] friends'. Marilyn† had a hysterectomy at age twenty-nine followed by an early menopause for which she was unprepared and uninformed. Pamela† also approached menopause feeling uninformed and not knowing 'what exactly' to expect:

I don't think I ever discussed [it] with my mother, as we were not very close and that generation don't like discussing that sort of thing. But, I think she went through hers early because she screamed and cried a lot and was very, very hard and strict on me...when I look back now I guess she must have really suffered.

In Pamela's† experience 'most women don't want to talk about it, they find it embarrassing'.

Among the remaining women, Moira, Annette\*, Kath\* and Jacky\* did not anticipate any problems during menopause. Moira had talked with her mother who had not experienced 'any major problems' and had found the subject was discussed among certain groups but not among the 'mainly younger folks...I work with'. Her attitude was that menopause was a 'part of life' and she expected to 'get on with it'. Similarly, Annette\* and Jacky\* viewed menopause as a natural process and did not anticipate any difficulties. Annette\*, who felt she was well informed, came to the conclusion that 'people who had problems were probably a bit more nervous about it and were easily up tight' (which implies the need for a positive mental attitude as argued by Beverley†). She had not discussed menopause with her mother because:

...my mother went through a different experience....She had a hysterectomy...in her early forties and I never sat down and said what effect did that have. It wasn't something I was sharing.

In contrast, Jacky\* had not had the opportunity to discuss the subject with her mother because she lived overseas. Neither Annette\* nor Jacky\* found it easy to talk with others about menopause, although Jacky\* had shared experiences with one friend. Annette\* observed that it was 'not the sort of thing you drop into conversation'. Kath\*, who had emigrated from Scotland as a young woman, was also not around to observe her mother's menopause nor had she had the opportunity to talk with her about it. She was, however, acquainted with the experience of an aunt. In common with Annette\*, she had, prior to menopause, associated problems with personal weakness:

I was going to ignore [it]. I thought it was something that you could be positive about and so therefore it wouldn't affect me. Let it pass! I do remember hearing that my aunt had gone through menopause by the time she was about thirty-eight and thought that would happen to me.

Zelda, Sally and Colleen indicated that their expectations of menopause were constrained by a lack of information. Zelda, for example, commented 'I never knew what it was exactly apart from the end of ovulation and periods, [but] I used to hear

women talk of hot flushes and sleeplessness'. She regarded the fact that her mother had never discussed any matters concerning female sexuality as 'a carry-over of Victorian attitudes whereby women did not discuss these topics'. Despite her upbringing, Zelda did talk about menopause 'with friends and colleagues of [her] own age'. Similarly, neither Sally nor Colleen had talked with their mothers about menopause but were able to do so with friends. Sally wrote:

I don't feel that many women talk about menopause, but I have made a point of mentioning it to my friends, particularly those who have not been through it in order that they may be prepared for whatever symptoms they should experience.

Jan, Joyce\*, Judy\* and Bella\* had all undergone hysterectomies prior to reaching menopause.<sup>15</sup> Like Marilyn†, Bella\* was surprised and unprepared for early menopause as the result of the surgery. Jan, who had a hysterectomy in her mid thirties due to an 'extensive period of bleeding caused by a very stressful situation', also felt uninformed about menopause. She wrote that she had had 'very little discussion' with her mother and that:

...women discuss menopause after the event or in response to enquiry. [The] most common comments appear to be:

My husband blamed menopause for the weirdest things.

Son suspected menopause caused odd things but for goodness sake don't ask or get involved.

Daughter says 'You'll be right soon', thinking this will never happen to me.

Judy\*, who also had a hysterectomy in her thirties, recollected that she 'wasn't told anything at the time' and was left unsure about when menopause would occur and what it would involve. It was not a subject talked about among women or ever mentioned by the aunt who raised her. Joyce\*, who had a hysterectomy in her early forties, expected to go through a 'normal' menopause even though she knew little about it and had not talked with her mother. Demonstrating her awareness of the changes occurring in society, including the breakdown of the taboos on matters of sexuality, she reflected that her mother, like most women of seventy years of age and over, 'didn't talk about things like that. It is only in my generation that people are starting to talk about sexual things'.

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<sup>15</sup> Unlike the other three, Bella\* had undergone a total hysterectomy (the removal of both uterus and ovaries).

### **The Onset of Menopause**

The women's expectations of menopause give an impression that they are better informed and feel less inhibited talking with others about such matters of female sexuality than the two older age groups. Although only three of these women had talked with their mothers, sixteen had discussed it with their friends and some, such as Sally, made a point of raising the subject with others. As a result, this age group had a broader, richer fund of shared common sense knowledge in comparison with those aged sixty and above. Women in their fifties, therefore, were generally more aware of the significance of body changes and commonly recognised menstrual irregularities as the first sign of menopause.

Barbara\*†, Beverley†, Marie†, Marilyn† and Pamela† identified a range of experiences signalling the onset of menopause. In contrast with the other women, Barbara\*† was experiencing a late menopause and still having erratic periods at the age of fifty-six. In recent years she had also experienced bouts of hot flushes and the occasional night sweat, although both these symptoms had disappeared at the time of interviewing. In Beverley's† case, the onset of menopause was signalled by menstrual irregularities and 'the occasional hot flush'. In contrast, Marie† and Pamela† experienced a range of symptoms in addition to irregular periods. Marilyn's† situation of a surgically-induced menopause was different. Lacking the obvious sign of menstrual change, Marilyn† experienced uncertainty as to the nature and treatment of the symptoms she experienced. She wrote 'I can remember at the onset of menopause [in 1975] the doctor was not overly helpful, probably because at that time most doctors did not know much about it'.

Barbara\*† and Beverley†, in common with the majority of the women, reported menstrual change was sometimes accompanied by symptoms such as hot flushes. Moreover, a number associated the onset of menopause with worsening PMS. Helen, for example, wrote:

Prior to the forty-plus mark I had relatively little problems [with my period]. Occasional cramps only. I have suffered only in these latter years what I now understand as PMS. I don't really recall it before my mid-forties or didn't recognise it as such. I now know I have moods and tell the family when it is 'that time'. Little things...can be blown out of proportion. I can get delicate and weepy and feel useless, [as if] everyone wants a piece of me. [I get] bloated so my skirts and jeans won't fit. [My] leg veins are a problem [and] I get purple feet....I have to

plan ironing around those first menstruation days as my legs ache like mad - on bad days I am like a monkey pacing from side to side and not standing still because of the bad ache. I believe I will only get relief when all menstruation has finished.

Colleen's\* experience was a little different. She recalled how PMS had 'crept up' on her:

I was always ratty a week before my period anyway but it just gradually extended and it was two weeks [duration] and then it was three weeks ...until I was feeling grotty all the time.

In contrast with the others, Gail\* had no apparent warning of the onset of menopause. Her period suddenly stopped when she was forty-five years of age. She had a pregnancy test that was negative and her doctor said, 'Well you are into menopause'. Merle and Rita\*, on the other hand, attributed the onset of menopause to concurrent stress in their lives. Merle wrote:

I think my menopause started when I was forty-two, although it could have been the shock of four close deaths in the one year. One a grandchild, then my sister eighteen months younger than myself. Then both parents of my husband at different times. I only had three periods that year, when I was normally every twenty-eight days.

Because an ongoing medical condition masked the early signs of menopause, Kath's\* situation was a little different:

I have thyroid problems and I don't quite know whether [menopause occurred] before I knew it and it was being blamed on the thyroid...but the symptoms were very definite and I suddenly realised that 'Hey, this is not just thyroid trouble', it was probably menopausal and I went to the doctor and worked through it with him.

The three women who had undergone hysterectomies involving removal of the uterus only, experienced symptoms of menopause around the normally expected time. The absence of menstruation left them, however, without the most tangible indicator of the onset of menopause. For example, ten years after her hysterectomy, Joyce\* started having hot flushes and night sweats in her early fifties and wondered if they signalled the onset of menopause. Jan 'assumed that [her] mild depression, lowered self-esteem, short fuse and shyness', which suddenly developed when she was forty-five, 'could be associated with menopause'. Judy\*, on the other hand, admitted 'It's only since last year that I actually found out that I was going through 'the change' through a blood test'. She explained:

I was going to a male doctor [and] I said to him that I had read an article that you could have a blood test done to see if you were going through the oestrogen change and I asked him about it. He said he had never heard of it [and] if it's 'the change' [that is causing you problems] then you have got to put up with it'. I wasn't that impressed and when he took on a lady doctor (she's only there in the afternoon) I found I couldn't go in the mornings! She has been

absolutely wonderful to me. I had the blood test done and she put me on HRT and I have been a lot better on that.

Bella\*, who had undergone a surgical menopause, had a different experience:

I had endometriosis...[I was] looking forward to that time when things were going to be fine but after the operation I didn't realise that I had had a total hysterectomy. I was probably away with the fairies [when the doctor told me]...because it was a shock....I did not realise I would have to go on HRT. I asked the specialist how long [would] I be on the hormone pills...and he said 'Until you are in your mid-fifties'. When you are coming up to forty that seems an awfully long time to have this hormone pill!

### Coping With Symptoms

Barbara\*†, Beverley†, Marilyn†, Pamela† and Marie† attributed a wide range of symptoms to menopause. All five experienced hot flushes and, apart from Marilyn†, night sweats in addition to other symptoms. However, they differed in their responses and coping strategies employed. Barbara\*† and Beverley† did not use any medication and managed their symptoms through a positive mental attitude. As already indicated, Barbara's\*† response to hot flushes was affected by her grandmother's perception that they were 'like gold' and she resolved to 'just go along with it'. She adopted a similar approach to night sweats and would 'just put [her] feet out the side of the bed...and they would be gone'. Beverley†, as a firm believer in the 'power of the mind', controlled her flushes through a daily strategy of positive affirmation when she would repeat to herself 'I am hot sweat free and my hormones are in perfect balance'. Marie†, who experienced headaches, insomnia, forgetfulness and feeling tearful, described her need for relief and her eventual discovery of homeopathic remedies following initial treatment with HRT. Pamela†, on the other hand, details one of the more distressing and debilitating experiences of symptoms which included insomnia, depression, panic attacks and various somatic disturbances. Initially opposed to taking HRT, Pamela† unsuccessfully sought relief from a range of alternative strategies including homeopathic, Chinese herbs, exercise and diet. After viewing a video on HRT, Pamela† decided 'she had to have a go'.<sup>16</sup> At the time of writing she had been on HRT for three months and finally felt she had acquired 'a stronger quality of life...even though [it was] chemically induced'. Marilyn† also found treatment with HRT improved her quality of life and had reached the point where she recognised that she 'couldn't have got by without it'.

<sup>16</sup> Pamela's description of the video suggests it was *The Change of Life* produced by Ciba-Giegy. If so, this video is one of those examined in Chapter 4.

In total, fifteen of the twenty-three women in their fifties were either currently taking HRT or had been on the treatment at some stage for the relief of symptoms. In common with Marie†, both Joyce\* and Jan tried HRT but ultimately opted for alternative strategies. 'I did have HRT tablets for a while but I tried to do without them', said Joyce\*. 'I had to have something...because I was not sleeping. I took them for about six months.' Because of a family history of breast cancer and a preference for 'doing things naturally', Joyce\* felt uneasy about being on HRT and once she felt she had had 'a break' from her symptoms she came off the drug. Curiously, even though her symptoms returned once off HRT, she found 'I sort of coped with [it]. It didn't seem as bad [but maybe] I managed to cope with [it] better!' Jan, for her part, 'abandoned...HRT after eight months as useless':

I sought medical aid...[and] my doctor at the time said, 'Ah yes, HRT forever is the solution'. HRT did not work for me because it is passive. In 1994 I decided to help myself. I joined the Aerobic City Gym and have a weight lifting and exercise programme which I do four to five times a week. I walk as much as possible and...[I] swim whenever I can and love it! [I have also] altered my eating habits...and now feel so much better and more confident. A change to reflexology and homeopathy has also played a big part in my well-being.

Rita\* had been on HRT for only three months at the time of interviewing and felt it 'hadn't made any difference at all'. Perceiving herself as a person who was usually 'happy, ready to have a go at anything...who does [not] really worry too much', Rita\* described how she was feeling:

I am getting a lot of nervousness and anxiety and it seems to have got to the stage where I have it all the time. I can't control it, the symptoms are there all the time. You get palpitations... your stomach goes all churned up and your heart sort of...this area [around the chest] goes hot and cold, your arms can go hot and cold. Your legs can go hot and cold and in fact you feel blimbling awful. And not having suffered from depression or anything like that before this, this last few months has been strange.

Her doctor also prescribed tranquillisers and she had regular visits from a mental health nurse who had taught her relaxation techniques. According to Rita\* 'if you are really bad [the relaxation techniques] are no help at all'. Prior to taking HRT, Rita\* had consulted a naturopath who put her onto an oestrogen rich dietary supplement with no notable improvement after six weeks. Bearing all these details of her experience and treatments in mind, it was interesting to hear Rita\* report that during a recent tramping holiday her symptoms had disappeared. As a result, she was beginning to question whether a recent stressful chain of family events, including the death of her brother and

taking on a new business with her husband, were responsible, at least in part, for the way she was feeling.<sup>17</sup>

In common with Pamela† (see above), five of the women (Annette\*, Colleen\*, Judy\*, Moira, Pat and Sally) stated that they could not cope without HRT for the control of their symptoms. Annette\*, who had been on HRT for six years, said:

I found that...depression, wakefulness, hot flushes were all bothering me and [I have] quite a stressful job as well and my doctor didn't hesitate to suggest HRT. I did try and come off at one stage and the symptoms reoccurred immediately.

Annette's\* decision to go on HRT took into consideration her personal circumstances which involved a stressful job and a diabetic husband who was not 'by any means 100 percent well'. She needed not only 'to support him [but to] be strong myself'. Annette was also aware of the benefits of exercise in alleviating symptoms but felt she didn't really have the time.

Sally and Moira highlighted the difficulty and inconvenience of experiencing symptoms such as hot flushes and irritability while holding down responsible jobs. Moira, a service manager at a large hospital, had unsuccessfully tried 'Evening Primrose' and camomile tea for the control of hot flushes prior to being prescribed HRT five years earlier. She had recently attempted a slow withdrawal from HRT only to find that the hot sweats returned and were 'unbearable', particularly when they resulted in heavy perspiration. Moira wrote '[I] am pleased to say that [I am] back on HRT and life is normal again'. Sally, who works as a secretary/personal assistant, wrote that about five years ago:

...I experience[d] hot flushes, temporary loss of memory. [I] couldn't remember instructions given to me only minutes before [and] this happened on a regular basis until I went onto HRT. I also felt very irritable and found myself snapping at work colleagues and friends. I could not understand why I was acting this way. I felt totally out of control, a frightening experience.

Despite remaining on HRT, Sally has found 'there is still the odd occasion [when] I come out in a hot flush'.

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<sup>17</sup> Rita's\* point concerning the relationship between the experience of stress and the onset and/or severity of symptoms commonly attributed to menopause that may, in fact, arise from other causes, was also noted by Beth\*† and Merle. An association between stress and the severity of symptoms has previously been noted by Greene and Cooke (1980).

Colleen, Pat and Judy\* all reported unpleasant hot flushes and unsuccessful attempts to come off HRT. Colleen, although pleased to be symptom free, held mixed feelings about the treatment:

I have tried to do without HRT but found I couldn't cope with all the symptoms returning. I don't like taking pills of any sort and yet I found I had to take [HRT] to get relief...

Pat, like some others, tried a range of alternative remedies such as Vitamin E and Chinese herbal pills but found them ineffective and was prescribed HRT. Her dislike of taking drugs motivated her to come off HRT but her symptoms returned:

...the hot flushes were very debilitating, especially at work. They'd start with a catching of breath and then the horrible reddening and heat around my chest, face and head. I [got] hot flushes at night too, waking me from sleep. Not drenching enough to need to change sheets and night wear, but definitely enough to need a shower when I got up...

Judy\*, on the other hand, did not share the unease of Colleen and Pat over taking HRT. She had discussed possible side-effects with her doctor and felt quite reassured:

You have got to be careful...for instance I have had a lump removed from my breast. I said to [the doctor] 'I thought you couldn't take HRT if you had anything wrong with your breast?'. She sent me for a mammogram and I have got a small cyst but she said I will be all right....I am to have a mammogram every year.

Labelling HRT a 'miracle drug', Judy\* was delighted with the absence of 'disgusting' hot flushes and 'the feeling of well-being' she experienced from it.

The severity of the symptoms experienced by Colleen\* and Kath\*, and a total hysterectomy in the case of Bella\*, meant that none of these women could manage without HRT. Colleen\*, who described earlier how PMS 'crept up' on her and left her 'feeling grotty' all the time, explained how she felt prior to being prescribed HRT:

The hot flushes started first and then I started having interrupted sleep and just sort of panics ...I would wake up at four o'clock in the morning and my heart would be going bang, bang, bang and I would have this terrible despair about anything and everything...I felt so down, so depressed...I didn't [want to] get out of bed. I feel I am fairly strong-minded and strong-willed and if I could have pulled myself up I would have. I just couldn't.

Because her doctor would not acknowledge she was having menopause-related problems, she consulted a specialist who 'wrote out a prescription for HRT on the spot - just like that!' After a period on HRT, Colleen\* spoke with a friend who was successfully controlling her own symptoms with herbal preparations:

I thought 'Oh that sounds good!' So I took these incredible things...and I gradually weaned off the oestrogen...and it wasn't very long and I was getting all my symptoms back again. I panicked and thought 'This is not worth it'. I couldn't afford to sink that low again.

At the time of interviewing, Colleen\* had been on HRT for six years, was feeling 'more stable' than in earlier years and felt she was 'getting better and better'.

Kath\*, her situation complicated by thyroid problems, had a similar experience to Colleen\*.

...I was waking up about four o'clock in the morning [with] real anxiety attacks...on what was happening around me. That had never in my life happened [before]...I would be awake for some time...

In addition to anxiety attacks, Kath\* also experienced mood changes and found these difficult to manage, particularly in her role as a teacher. As soon as she went on HRT she was better able to cope, her symptoms eased and she felt less tired and had more energy. Although not game to come off HRT, she hoped, like Colleen\*, that one day perhaps she might be able to do without it.

The remaining eight women who had never been treated with HRT all reported a variety of symptoms and coping strategies. Although Gail\* found hot flushes, night sweats and slight depression uncomfortable and bothersome, it was problems with her short-term memory that were the most difficult to deal with. In order to compensate for her forgetfulness, Gail\* deliberately made a joke of her memory, telling colleagues and friends 'I am sorry but you will have to excuse my menopausal memory'. She also adopted a strategy of verbalisation:

I verbalise [as I am] doing things. 'I am turning off the iron' 'I have done the stove'...because one of the problems was that I would leave the house in the morning to go to work and I would get to work and I would think 'I haven't turned off the grill that my son used for the toaster'. And I would have to go back and check. It just takes up so much of your time!

Merle and Helen also reported memory problems. While Merle offered no details, Helen wrote:

Between 1992 and 1994 particularly, I was having bad memory loss [and]...I thought I was going 'mad'. The family joked about my 'Alzheimer's' until it wore thin with me. Quite a worry. Then I read [about it] in a pamphlet for women on HRT/menopause. Bingo!

Helen also experienced hot flushes, palpitations, sleeplessness, problems with PMS, (described earlier) and - for the first time in her life - problem acne. Advised against HRT on account of a family history of breast cancer, she turned to alternative strategies:

I have tried Evening Primrose Oil tablets and [I] didn't notice any difference. I'm now advised to try Vitamin E and B and Zinc groups. I understand the need for continued exercise, good nutrition, hobbies to enjoy spare time.

Zelda and Margaret both viewed menopausal symptoms as normal and natural, but for different reasons elected to cope on their own. Zelda, who experienced insomnia, hot flushes and night sweats, was 'forbidden' by her surgeon to take HRT because of an

earlier bilateral mastectomy. She wrote, 'I feel fine about my present experience. I understand it as something my body has to go through and I accept it as part of the ageing process'. Margaret's symptoms, on the other hand, were limited to erratic bouts of what she described as 'heat up periods' which lasted about two minutes. No particular treatment appeared to be warranted.

### Reflections

Dominating the views of this age group was their recognition of menopause as a natural process. Moira was typical. Accepting 'the experience of menopause as part of life' she put it into the background except when the perspiration was pouring off her. Obviously many of the women found the symptoms uncomfortable and embarrassing, and a common complaint was that they left one feeling 'out of control' as Rita\* explained:

I do [feel embarrassed] because everyone I have told about being nervous was so surprised because they don't really think I am that sort of person... I do really [feel out of control]...you know I feel nervous going down to the shops, the supermarket.

In a similar vein, Sally reported that she 'felt totally out of control'.

Among the twenty-three women in their fifties, only Barbara\*† and Beverley† acknowledged menopause as being an easy and positive process. The perceptions of the remainder ranged from ambivalent (fourteen out of twenty-three) to negative (seven out of twenty-three). Typical of those who viewed their experience ambivalently, as a stage in life 'you just get on with', was Merle who merely stated 'I felt I could cope'. In contrast, Marilyn†, Pamela†, Annette\*, Kath\*, and Sally all found it a difficult and even negative stage in their lives. Marilyn†, for example, described how in the early phase she felt 'really bad...almost suicidal', while Pamela† described her experience as 'the worst five years of my life'.

The nature and severity of symptoms caught a number of women by surprise, many felt unprepared and ill-informed on what to expect and others were frustrated over difficulties of access to the information and support they needed. In other words, despite the greatly reduced force of taboo, hence the opportunities for discussion and access to a wider range of sources from which increments could be made to their fund of common sense knowledge, there were still gaps relative to their (apparently

increased) needs or requirements. For example: Pamela† was unable to obtain clarification on ‘when exactly are you menopausal and when do you become normal again’; Sally wanted to know ‘the length of time one can expect menopause can take’; and Gail\* felt that her experience may have been ‘a bit easier’ had she been better informed and ‘perhaps tried HRT’. In this context, most found their doctor supportive, helpful and easy to talk with, but a few, such as Colleen\* and Judy\*, changed their practitioner in order to get the help and sympathy they required. Judy\* described her frustration when told by the first doctor she consulted ‘If it’s ‘the change’ then you have to put up with it’. In Jan’s case, however, an offer of antidepressants for the relief of hot flushes left her feeling very angry:

My strong wish after that visit was that my doctor would experience hot flushes during difficult consultations, any form of concentration, in hot weather and any other time that they’re so damn inconvenient! Men should be totally excluded from anything to do with menopause. They honestly do not understand.

The importance of support and understanding from husbands, families and friends was also emphasised by most of the study participants and respondents. Indeed, a number commented with appreciation on the support they received. Colleen, for example, remarked ‘I get sympathy and support from my partner and close friends that matter to me. This makes me feel I have control’. Others commented on their need for affection; a need which Colleen\* admitted she ‘craved’ at times.

There was a range of views on the most appropriate strategies for the management of menopause. Barbara\*† and Beverley†, for example, associated their ‘easy and positive’ menopause experience with ‘being such a good sleeper’ and ‘positive thinking’, respectively. Characteristic of the women who successfully managed their symptoms through lifestyle and/or homeopathic remedies was their enthusiasm for the strategy and a feeling of being in control. For example, Marie† wrote ‘now I have found homeopathy I wouldn’t touch HRT’, while Jan’s regime of diet, exercise and homeopathy led her to the view that ‘Doctors have got to advise their patients to truly ‘go get a life’ instead of prescribing all these drugs!’ The difficulty with these strategies, however, is that they may not be as effective for everyone, and in opposing medicalisation the women unwittingly universalise the body. In so doing they make the

same assumption that the medical model is accused of and create a climate where women who choose to take HRT are regarded as being 'weak'.

The desire for a better quality of life was unanimous among those women taking HRT but there was often a tension between their need to alleviate symptoms and a regime of treatment with pharmaceutical drugs. None of the women on HRT felt they 'could cope without it' but most harboured reservations about possible side-effects of the treatment. Pamela†, for example, 'succumbed' to the treatment out of sheer desperation despite feeling she was betraying her body 'by going chemical' after years of trying 'natural' products. Colleen\* and Kath\* felt they had little choice other than treatment with HRT, the former commenting she would prefer not to have to rely on drugs but 'If I wasn't on HRT (and I am not dramatising) I would be in a mental institution'. Pat, after the 'fruitless' use of alternative strategies to control hot flushes, remarked 'I would feel happier...if I was able to read information that was as factual as possible and did not originate from the companies producing [the drug]'. In contrast, Moira and Judy\*, who viewed HRT as a 'miracle drug', held 'no misgivings' about the benefits or side-effects. It seems likely that this tension between the need to alleviate symptoms and the use of drugs, where it existed, stemmed from the eclectic, disjointed nature and construction of common sense knowledge and its inherent contradictions.

### **Commentary**

The women in their fifties were the largest group in the study to classify themselves as either 'in' or 'through' menopause. In contrast with the older women, their experience of menopause was more immediate and their accounts and reflections more detailed. In general, they were less inhibited about publicly discussing menopause with their peers and so had freer access than the older women to a broader range of knowledges and were better informed of the signs of its onset. A downside was the circulation of 'horror stories' which left some of the women feeling apprehensive about the approach of this event. Overall, they felt negative or ambivalent about their experience with only two perceiving menopause as a positive stage in their lives.

Taboo and stoicism continued to influence the women's experiences, although to a much lower degree than was evident among the two older age groups. Only three of the women had talked with their mothers about menopause. The refusal of older women to discuss anything related to female sexuality and, in a few cases, inappropriate personal circumstances, accounted for the lack of mother/daughter communication on the subject among the remaining women. Although diminishing in its impact, the ethic of stoicism still informed the attitudes towards menopause of just under half of the women. In particular, the view that at menopause women should 'just get on with it', and that an inability 'to cope' with symptoms was a sign of personal weakness, continued to be expressed. However, among a small number of the participants and respondents the pressure to stoically endure symptoms was tempered by a new realisation that 'getting on with it' could be achieved with medical help in the form of HRT. In other words, these women articulated what Beth\*† (seventy and over age group) and Sylvia (sixties group) only hinted at. Namely, that the desired control of menopausal symptoms was not dependent upon a strategy of individual self-control but could be attained via professional physiological control that included the services or assistance of herbalists and homeopaths.

In comparison with the two older groups, the experience of the women in their fifties was marked by a noticeable change in their knowledge, practice and attitudes. In the case of the women's knowledge, two changes occurred. The first involved the emerging emphasis on worsening PMS as a precursor to menopause. Of interest here, is the fact that no mention at all was made by the older women of such a condition, apart from the fact that they were glad to be free of 'pre-monthly' discomfort such as headaches and sore breasts.<sup>18</sup> Consequently, the question that needs to be asked is how can a previously unrecognised condition suddenly feature as a dominant aspect of the experience of several of the women in this age group?

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<sup>18</sup> An overview of the responses of all the women in this study reveals that the younger the woman the greater the emphasis placed on the experience of PMS. In particular, PMS seemed to dominate the lives of most of the women yet to reach menopause, many of whom provided vivid descriptions of the debilitating nature of this complaint (see, for example, the narratives of Mary Ann\*, Marie\* and Nora\* in Chapter 6).

Davis (1996:58) notes that PMS first emerged in the medical literature in the 1980s. Aside from documenting claims on the dubious scientific basis of medical identification of PMS, Davis concurs with others that the classification of pre-menstrual physical, psychological and behavioural change as a hormonally activated syndrome parallels nineteenth century constructions of female hysteria and neurasthenia.<sup>19</sup> Of particular concern to a number of feminist writers is the emphasis given to behavioural and psychological change associated with PMS. For example, Fausto-Sterling (1992:93-94) provides examples of media headings which make claims such as: 'Pre-menstrual strain linked to crime'; 'Erratic female behaviour tied to pre-menstrual syndrome'; and 'Violence by women is linked to menstruation'. Oakley (1993:14), on the other hand, draws attention to the acceptance of PMS as a legitimate defence in law. In other words, medical 'discovery' of PMS perpetuates the ancient notion of the female body as a threat to the moral and social stability of society. Moreover, the reclassification of pre-menstrual change as a medical syndrome ensures social control of the female body through the process of medicalisation. One result is that women have reconceptualised the functioning and experience of their bodies prior to menstruation. As Davis (1996:62) points out:

Although the symptoms attributed to PMS are...[not] unique to Western industrial cultures...their configuration into a specific, medically formalized syndrome or disease category is unique. Western women have learned their behaviour from medical scripts and PMS as a medical, legal entity has become part of popular lay culture.

The second change in the women's knowledge concerned the much wider range of symptoms attributed to menopause. Among the two older age groups, the most commonly reported symptoms were hot flushes and night sweats, frequently accompanied by tiredness. In contrast, those in their fifties commonly reported sleep disruption, memory loss, depression, mood swings, irritability and loss of confidence,

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<sup>19</sup> Davis (1996:58-59) documents a number of flaws in clinical PMS research identified by various researchers. These include: a lack of agreement on which symptoms should be considered as the defining criteria for PMS; lack of agreement on the time-frame within which the symptoms should occur; lack of agreement on when normal psychological or physical stress associated with menstruation becomes pathological, and an associated over-estimation of PMS rates; lack of scientific verification of the etiological explanation of PMS; and the inability of successful treatment regimes to survive rigorous clinical trials.

in addition to hot flushes and night sweats.<sup>20</sup> This apparent increase in symptoms attributed to menopause can be accounted for in two ways. First, that it is a result of the breakdown of the taboo surrounding menopause. The point here is that as more women begin to discuss the subject among themselves they are more likely to identify with aspects of the experiences of others and in so doing associate previously unexplained or unrecognised 'symptoms' with menopause. The second explanation involves the manner in which the promotion of HRT raises popular awareness of the range of symptoms associated with menopause, as suggested by Davis (1996) in relation to PMS.<sup>21</sup>

In contrast with the women in their sixties, just under two-thirds of those in their fifties had been prescribed HRT with half remaining on long-term treatment. Among the latter group, most were unequivocal in their view that the treatment had improved their quality of life and that they 'couldn't get by without it'. Several of those taking HRT held responsible jobs and, in contrast with the older women, felt menopausal symptoms interfered with their ability to function effectively. HRT allowed them to remain 'in control' through suppressing symptoms such as hot flushes, mood swings and irritability which they perceived as embarrassing and socially unacceptable.

The experience of the women on HRT places them in a situation similar to those suffering from PMS. That is, medical redefinition of menopause as a process of hormone decline provides the mechanism for control of the female body through HRT, while at the same time reshaping women's perception and experience of this event. Among the older women, the control of menopause was achieved through the expectation of stoicism with conformity ensured through the sanction of social deviance. The consequences for those who had trouble conforming to these restrictions, however, were often traumatic. For the women in their fifties the social requirement of stoicism is being overtaken by the process of medicalisation, only in this case the carrot of conformity involves both the immediate control of symptoms and, in

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<sup>20</sup> The symptoms listed are those most commonly cited by the women. The women in the sixties and seventy and over age groups listed a total of thirteen symptoms experienced at menopause while those in their fifties identified a total of twenty-four.

<sup>21</sup> See Chapter 4, in particular Tables 4.4 and 4.5.

the longer-term, a disease-free body. Consequently, those who do not use hormone replacement to control their bodies could be viewed as at risk of social, moral and physiological deviance.

There are two inferences here. The first, identified by Estok and O'Toole (1991:32), is that if:

...observers believe that a woman who is experiencing menopause has control over (is responsible for) the 'impatience and irritability' that is attributed to 'that age', the woman may be subject to sanction and loss of social interaction by co-workers and others if she continues such behaviour.

The second is, that not only does a woman's refusal to go on HRT knowingly place workmates, family and the community at risk if she is unable to control her behavioural symptoms (such as mood swings, irritability and so on) but it may also imperil her long-term health (through the medically identified increased risk of osteoporosis and heart disease). Indeed, Kaufert and Gilbert (1986:11) point out that when menopause is:

...defined as a problem of declining oestrogen levels...changes in menstrual patterns, the end of menstruation, the experience of hot flushes become symptoms of an underlying disease process which women are under an obligation to report to a physician and physicians are under an obligation to treat...the old woman who fractures her hip...becomes a burden on the health care system. The [medicalisation of menopause] invokes not only the suffering of the individual, but the greater good of the community...

The difficulty is, however, that women may be caught in a no-win situation, due in large part to the ambiguities surrounding HRT as a strategy of both symptom relief and of long-term health promotion. If women opt to take HRT in order to 'control' symptoms they also risk being judged by opponents of medicalisation and HRT as weak, neurotic and 'letting the side down'. If, on the other hand, they choose not to take HRT, they risk being judged as physiologically deviant for failing to take responsibility for their long-term health and well-being (see the latent message of the Australasian Menopause Society workshop in Chapter 4).

The women's practices did, however, exhibit a degree of resistance to the process of medicalisation in three ways.<sup>22</sup> The first concerned the desire of some of the women to proceed through menopause 'naturally'; that is, without the aid of HRT. In fact, a

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<sup>22</sup> This issue is examined in more detail later in this chapter in the commentary on the women in their forties.

notable contrast with the older women was that those in their fifties had at their disposal and employed a greater range of 'natural' strategies such as lifestyle modifications (e.g. diet and exercise), mind techniques (positive affirmation), and complementary medicine (e.g. homeopathy, reflexology, and vitamin and herb supplements). The second form of resistance related to the fact that none of the women viewed menopause as a deficiency disease and, indeed, most emphasised that it was a normal, natural life-stage. Those on HRT resolved the apparent contradiction (i.e. between their view of menopause as a *natural life-stage* and their use of a 'chemical' treatment for *a disease*) through the rationalisation that HRT merely provided a new and more effective means of 'getting on with it'. In other words, they viewed HRT as merely an aid which allowed them to 'take' or 'remain in' control of their lives during the menopausal transition as opposed to the medical view of HRT as a long-term health promotion strategy. Finally, a few of the women who had started on HRT experienced unease over possible side-effects and 'putting chemicals' into their bodies, and had switched to 'natural' strategies or stoic endurance of symptoms. In such cases, the outcome was an expression of confidence and satisfaction over the negotiation of menopause 'naturally' and a sense of 'being in control' of their body. A similar observation is made by O'Leary Cobb (1994:529) but she does not go so far as to describe it as a form of resistance to medicalisation.<sup>23</sup>

The desire to 'control' the body and/or to proceed through menopause 'naturally' emerge as dominant and repetitive themes among members of this age group.<sup>24</sup> The women's desire to control the body was manifest in two distinct ways. The first involved those who perceived their experience of symptoms as severe, embarrassing and/or an impediment to effective functioning in their chosen career. Characteristic of these women was the retrospective comment that they felt 'out of control' of their body until effective relief was obtained through use of HRT. The second, involved those women who had abandoned treatment with HRT in order to 'regain control' of

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<sup>23</sup> The distinction between 'natural' and 'chemical' treatments is curious given that both constitute 'treatment'. However, the reasons underlying this distinction were not explored in this study and remain an area for future investigation.

<sup>24</sup> The women's use of the word 'natural' conveyed two meanings. In relation to the management of menopause it was employed in the sense of opposition to 'artificial'. In contrast, their view of menopause as a 'natural' life-stage was an essentialist one.

their body through implementation of self-managed, 'natural' strategies. The desires of both groups can be recognised as a reaction to the medicalisation of menopause, with the first group 'buying in' to the notion of external professional management of menopause, while the second reacted by 'opting out' in favour of individual lay management. Ironically, both strategies conform to and so perpetuate the common sense practice of stoicism, albeit in different forms - HRT facilitates 'getting on with it' in a form of pseudo-stoicism, while the rejection of medicalisation relies on embracing the conventional strategy of stoicism. In both cases the women's comments suggest the actions of a self-determining agent; that is, their ability to self-regulate the body, free from external interference. However, as Csordas (1994: 53) argues 'the body is a subject of (and subject to) social power....The human capacity for social agency...comes precisely from the person's lived experience of embodiment', which in this case was shaped and constrained by the body politic through the mechanisms of stoicism, taboo and medicalisation.

Finally, the span of thirty-two years between the earliest onset of menopause among the older women in 1963 and the latest onset among the present group in 1995, represents a period of marked social and economic change both globally and within New Zealand.<sup>25</sup> The women in their fifties were still primarily educated to be wives and mothers. As a result they typically under-achieved educationally and lacked the encouragement and guidance to seek tertiary qualifications except in the areas of teaching or nursing. Their status and success primarily depended on a successful marriage, after which they did not expect to return to the paid workforce. However, the changing social conditions meant that a working wife/mother became socially acceptable and many women in this age range, after an interval of five to ten years as a mother and housewife, returned to often part-time employment which frequently expanded into a full-time job. As part of this change, they have also become more prominent among mature students seeking further qualifications (Park, 1991:46-50).<sup>26</sup>

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<sup>25</sup> Joyce\* who underwent a surgical menopause in 1955 has been excluded from this group.

<sup>26</sup> For a general description of the demographic, socio-economic and health characteristics of the combined forty to fifty-nine age group in New Zealand in 1991, see Davey (1993:115-137).

The changing role of women in this country is evident, for example, through the women's comments that menopausal symptoms interfered with their ability to effectively function in a responsible job.<sup>27</sup> The point is that among the older women (especially seventy and over) their role was generally confined to the domestic realm as full-time housewives and mothers. While some of these women did re-enter the workforce once free of family responsibilities, these opportunities tended to be limited to semi-skilled and often part-time work free from the responsibility expected of a career position. As one of the women pointed out, in her mother's day it didn't matter if sleep was disrupted by menopausal symptoms as 'she could sleep-in in the morning, or catch a nap during the day if she needed to'. For the women in the fifties age group, however, the demands of employment, especially in positions of responsibility, mean that concessions to impaired functioning and an inability to control signs of a 'deviant' female body are not tolerated by themselves or others. In light of the claim of Kaufert and Gilbert (1986:11) that the medicalisation of menopause 'invokes not only the suffering of the individual, but the greater good of the community', an inability to control the menopausal body risks being perceived as social, moral and physiological deviance.

### **WOMEN IN THEIR FORTIES**

A total of sixteen women aged in their forties classified themselves as 'in' or 'through' menopause. Of these women, three were from the Feilding-Manawatu district and the remainder were *NZWD* respondents who lived in Auckland (Lois and Sue P†), Christchurch (Rosie), Darfield (Rosie D), Greymouth (Ruth), Hamilton (Kath), Invercargill (Shona), Papamoa (Sue O), Rangiora (Monique†), Taranaki (Paula), Tuakau (Gay†), Taupo (Megan), and Wainui (Christine†). The onset of menopause for these women occurred between 1981 and 1995, with the majority in the period after 1990.

### **Expectations**

The women in their forties exhibited a range of expectations. In common with the

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<sup>27</sup> This was undoubtedly a factor which contributed to the tension noted earlier between the need to alleviate or manage symptoms and a regime of treatment with pharmaceutical drugs.

viewpoints of Ainslie\*†, Janice\*, Paula and Gay†, most of these women considered menopause an event which affected older people and had not expected to reach this stage until they were in their fifties. In contrast, Kath eagerly anticipated liberation from menstruation and wrote ‘Yes, they’re [periods] going to stop... Great Jubilation! I’ve contemplated a menopause party’. Monique†, Rosie, Catherine\*, Christine† and Lois, on the other hand, felt apprehensive and ill-prepared.

Remnants of the taboo surrounding menopause were apparent in the reluctance and/or difficulty that a number of the women experienced in discussing the subject with their mothers as well as in the attitudes of some friends and acquaintances. Gay† recalled her mother mentioning menopause, albeit obliquely. Lois and Sue P† assessed such conversations as of ‘no assistance whatsoever’; the mother of each had little to say and her experience was vastly different to that of her daughter. Monique† described her mother’s inability to be ‘forthcoming...[and to] discuss private things like menopause’, in addition to her attitude that you ‘just get on with it’ which did little to allay her trepidation. For both Rosie and Christine† it was also a case of a mother reluctant to discuss menopause, Janice’s\* mother was ‘a very private person’ and in Paula’s family ‘sex, periods etc. [were] never discussed unless...obtusely in hushed secretive tones’ which made the subject difficult if not impossible to raise. For some, like Ainslie\*† and Kath, a mother’s death some time earlier was accompanied by only vague memories of her experience. Kath, for example, wrote:

My mother was forty-four years old when I was born so she was going through menopause when I was a teenager. Not a good time for either of us, but we pulled through okay. It did mean that she wasn’t around to discuss her problems in relation to mine as she died eleven years ago.

In contrast with the mother/daughter interaction, most found it easy to discuss menopause with others, particularly women of a similar age. Rosie, however, observed that friends who had not yet reached this stage still regarded it as a subject for ‘older women’. Sue O found that discussions tended to be superficial, while Sue P’s† experience was that menopause continued to be a ‘taboo subject with women as well as men’.

### The Onset of Menopause

Overall, the women were less well informed than those in the fifties age group. The majority had expected menopause to occur around or after the age of fifty and as a result signs of menstrual change and/or menopause-related symptoms, particularly if they occurred before the age of forty, were frequently greeted with disbelief and even shock. Aside from Christine† and Rosie D (who experienced a surgically-induced menopause at ages twenty-nine and thirty-two, respectively), Sue P†, Lois, Shona, Rosie and Paula (i.e. five out of sixteen in this age group) reported the first signs of menopause while still in their thirties. In Paula's case it was a natural, early menopause which she reached by the age of thirty-six.<sup>28</sup> One obvious conclusion to be drawn from the above is that conscious exposure to knowledge in preparation for menopause is governed, in part, not only by early 'signs' but by a shared common sense understanding of when it is expected to occur. If this understanding is flawed (a not unusual feature of common sense knowledge) it will probably result in responses or reactions of the type noted above.

The sense of shock and being 'too young' for menopause was not confined to the women themselves. Several reported a similar reaction from others, including their doctor. Ainslie\*†, for example, identified the reaction of those around her - including her general practitioner - as 'Don't be stupid, not at your age'. Catherine\* reported a similar experience which she described as follows:

I hadn't had a period for about a year...and I was getting really irritable inside...and I wanted to scream and so I went to my doctor and said about the change of life because I wasn't getting any periods. He said, 'No, it won't be the change of life' and [I replied] I was sure it [was]. So he sent me for a blood test and it came back [negative]...so I carried on and still wasn't getting any periods so I went back again and whatever happened [I don't know]...he must have done the wrong blood test because the next...[blood test result] came out 'yes'.

For some of the women the only indication of the onset of menopause was menstrual change. Ruth, for example, wrote that when she was aged forty-three 'one month I menstruated and kept going for two to three months, then nothing since [apart from]...about three hot flushes...[and] some joint pains'. Others (such as Monique†, Megan and Ainslie\*†) commented on worsening PMS prior to experiencing menstrual

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<sup>28</sup> See Paula's narrative, Chapter 6.

irregularities, while a further group reported that menopause-related symptoms coincided with menstrual irregularities. Janice\*, for example, found that when her periods suddenly stopped for three months at the age of forty she ‘suddenly started having palpitations... then my periods started again and the palpitations stopped’.

### **Coping With Symptoms**

The women identified a range of symptoms and management strategies similar to those specified by the fifties age group. In order of prevalence, the symptoms most commonly reported were hot flushes and night sweats, memory loss, vaginal dryness, depression, mood swings, irritability and joint aches.<sup>29</sup>

Four of the women (Monique†, Kath, Rosie and Lois) were determined from the outset not to go onto HRT for the treatment of symptoms. Monique† describes her strategy for managing episodes of hot flushes, panic attacks, mood swings, memory loss and irritability as ‘a strange mental outlook and the odd prayer’. Her unwillingness to go on HRT stemmed from a bad experience with the contraceptive pill which had left her wary and unwilling to ‘put things like that in my body’. Kath, grappling with ‘bouts of night sweats and hot flushes’, wrote that during a visit to the doctor she was:

...asked... would I like to go on HRT treatment? I said ‘NO!’ I’m not convinced enough is known about what happens after ten to fifteen years of use of HRT and I don’t want a ‘bleed’ each month indefinitely.

The discovery of a book on menopause by an English doctor and attendance at a local series of seminars reassured Kath that her hot flushes and various other symptoms were ‘menopausal... [and although] they didn’t stop... at least they were explained’. Opting for diet and exercise as a management strategy, Kath felt more able to cope, was looking forward to being completely ‘period free’ and planning new challenges in her life. Rosie, for her part, was ‘not at all keen on yet another drug to keep women ‘right’. Educate us and our men and families, teach us some natural aids’. An avid exerciser, she was confident that exercise would lessen the impact of her symptoms even though at the time of writing it had not ‘alleviated the worst symptom - breast

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<sup>29</sup> The women identified a total of twenty-four symptoms as menopause-related. Although the total number identified was the same for the women in their forties and fifties, there was some variation between the two groups as to the actual symptoms mentioned.

tenderness'.<sup>30</sup> In contrast with Rosie, Lois's reluctance to take HRT sprang from an earlier scare with a deep vein thrombosis. Although her doctor favoured her use of hormone tablets, she was 'scared of getting another clot'. Aside from taking 'Dixirit' tablets 'for about a year [which] didn't help very much', Lois did not explain how she coped with her continuing symptoms.<sup>31</sup>

A further six women had been prescribed HRT but had discontinued its use in favour of alternative strategies. As the only woman in this age group to experience a symptom-free, natural premature menopause, Paula experienced difficulties in having her condition diagnosed. Advised by her doctor to take HRT as a precaution against the possible onset of osteoporosis in later life, she elected to:

...try it but after three months of wearing patches...I decided to investigate HRT for myself...I tried to discuss what I'd read with the doctor but it didn't achieve anything. He was disappointed that I'd made my mind up not to take [HRT] or wear patches. He feels I will suffer osteoporosis so I asked if I could have a bone density test [and] he said it was too expensive and I would have to go to Hamilton...I feel that it's wrong to prescribe something like that without finding out about it first. [It was] a hard decision, knowing that I could live to be eighty or ninety years old!

Ainslie\*†, dissatisfied with the side-effects of HRT, decided to seek alternative 'natural' strategies and attained successful management of symptoms with herbal therapy. In Ruth's case, an expectation that HRT would alleviate her body aches and stiffness was not realised. She 'gave up after three months' because her menopause 'was unbelievably uneventful and HRT wasn't an option'. Megan and Sue O, on the other hand, both experienced unpleasant side-effects from taking HRT and after trying alternative forms of the medication, like Ruth, opted to 'take nothing'. Although Megan occasionally used 'Estroderm' patches ('when symptoms compound') she felt 'prouder managing without them'. Sue O couldn't deal with the thought of putting chemicals in her body and 'couldn't believe that [she] needed to start a period again when [her] body was telling [her she] had finished'. Finally, Rosie D was prescribed HRT immediately after her total hysterectomy and informed that she 'would need to take [it] for the rest of [her] life'. Although HRT helped alleviate her hot flushes and vaginal dryness she 'couldn't imagine being on it for the rest of [her] life' as she was

<sup>30</sup> From age thirty, Rosie regularly participated in long distance running, cycling and weight training.

<sup>31</sup> 'Dixirit' is an agent which reduces the sensitivity of capillary vessels to vascular changes associated with flushing (Ian Low MPS, personal communication). It is also used in the treatment of migraine.

worried about the long-term side-effects. Rosie D turned to alternative strategies, found homeopathy and herbal remedies 'quite good' and only took HRT if she experienced vaginal dryness.

Because of the ability of HRT to effectively alleviate unpleasant and sometimes debilitating symptoms, the remaining women were convinced of its benefits and, apart from Catherine\*, did not share any of the concerns identified above. In Shona's case, 'plentiful and frequent symptoms' left her feeling 'quite unwell' and struggling to cope with the demands of running a hospital day surgery unit. Shona volunteered to enter a menopause study involving a double-blind medication trial and described the outcome as follows:

In the second and third month of the study I suffered dreadful headaches and with my GP's help and 'Dixirit' tablets...[over a period of] three weeks I was able to stay on the study medication. I have remained on HRT following the study and have no further headaches. I feel a changed person...just great and my life is worth living again.

As another example, Janice\* attributed a loss of self-confidence to menopause. She found social interaction very difficult because of 'panic attacks' and 'was scared to talk to anybody'. Her doctor suggested HRT which 'had made a big difference' although she continued to get tongue-tied and embarrassed. Aware that a family history of breast cancer placed her at higher risk from the disease, particularly if taking HRT, Janice\* felt reassured by her doctor's advice that 'as long as [she was] monitored...there [wasn't] anything to worry about'. Finally, Catherine\* laboured under the impact of hot flushes, joint aches, panic attacks and other symptoms. She tried Evening Primrose capsules without success and eventually sought help from her doctor who prescribed HRT. Not entirely happy about the medication, Catherine\* stopped the treatment after eighteen months only to find that her symptoms returned almost immediately. Reassured by her doctor as to the long-term safety of the treatment, she resumed HRT but regretted not being able to 'naturally do it'.

### **Reflections**

The negative view of menopause held by slightly less than one third of the women in their fifties was also evident among half of those in their forties, while the remainder were either positive or ambivalent about their experiences. The intensity of the negative perception ranged from Sue P's† comment that 'it sucks. I can't wait for it to

be over and then I can begin to live again', to Lois's more stoic reflection, 'I actually think I had a hard time going through menopause'. As indicated by the examples and discussion that follows, it may be argued that these perceptions of menopause reflect essentialist notions of femininity which inform the women's common sense understanding and knowledge of menopause as well as the impact of the body politic in relation to physiological and social deviance.

Those who perceived menopause negatively, highlighted several factors which contributed to their views, in particular their feeling of being too young for menopause and its association with ageing. Janice\* put it this way: 'Once you get to that stage, you are getting older and your body is starting to [go into decline]'. In Paula's case, a premature natural menopause signified not only ageing but her inability to have more children, while Rosie noted that some of her friends regarded menopausal symptoms as an admission of being 'past your use by date'. She wrote 'its a relief to be able to talk about menopause...and not be laughed at or ridiculed'. Lois had similar experiences.

Embarrassment over the physical manifestation of symptoms in the presence of others and a feeling of being misunderstood were also associated with a negative view of menopausal experience. Shona, for example, had no problem with sharing information on menopause with her patients, but found sudden, unexpected flooding during the early stages of menopause (which obliged her to constantly take a change of clothes to work) difficult and embarrassing. Christine† found menopause a 'a very lonely time' and a 'very misunderstood subject'. Catherine\* shared a similar view and explained that:

I felt like there was nobody sort of understanding me. I found that a lot of times there I was screaming at [my daughters]...the girls and I would have an argument...[and] I [would be] screaming and wanting to smash something. That's how I was feeling.

The desire to remain 'in control', so evident among the women in their fifties, was also apparent. Sue P†, for example, wrote:

I just can't handle my body being out of control and betraying me, this [sic] affecting my lifestyle. In short, I just don't have time for all this physical rubbish and I wish it would hurry up and get it over and done with so I can get on with my life.

In Paula's case, her early natural menopause had 'robbed' her of the opportunity to have more children but she had retained some 'control' through her decision not to

take HRT as a long-term measure against osteoporosis. For Ainslie\*†, menopause presented an unforeseen opportunity to ‘take control’ through implementation of her own remedial strategies.

Of course, not all of the women viewed their experiences negatively or encountered negative attitudes from family and friends. Monique†, Ainslie\*† and Gay† all emphasised the support and understanding received from their husbands and, like Janice, several appreciated the support and understanding received from their general practitioner:

...he was quite good. He had obviously recently been to something about menopause...I just burst into tears in his room and as soon as I started talking to him he said, ‘I think it is time you tried some hormones’, without me even asking.

Others, such as Gay†, although encountering some negative attitudes and comments towards menopause in the workplace, also noted the support and interest received from female colleagues and younger men. Indeed, the ability to share and discuss experiences with female workmates was a feature of the experience of many of the women.

Finally, the positive view among some of the women stemmed from a sense of pride at either having avoided or dispensed with medical management of their symptoms. Monique†, for example, expressed her satisfaction at having ‘coped with menopause [while] raising teenagers and at the same time...doing quite hard part-time work’ picking asparagus and apples. The stoic attitude and belief in the virtue of hard work, characteristic of older women, was apparent in her reflection that ‘it really is better to go out and keep busy’. For others (such as Ainslie\*†, Kath and Megan) the ability to manage their symptoms without the aid of HRT transformed a negative view of menopause into a positive one which signalled a new stage in their lives; a stage associated with a new-found confidence. Megan wrote:

At menopause I felt less inclined to be buffered by society - more free to be me, with no excuses or apologies. I feel a glorious womanly serenity and I suspect it emanates from me. I receive compliments in this sphere.

### **Commentary**

As the youngest of the four age groups of women who defined themselves as ‘in’ or ‘through’ menopause, the attitudes and experiences of those in their forties reflect a

changing social climate. In contrast with women in their fifties, this age group in New Zealand society appears to have been better educated, encouraged to choose a vocation and to pursue more challenging careers. However, those entering professional tertiary education (such as law, commerce or medicine) were primarily from the higher socio-economic groups. For women in their forties, marriage was no longer viewed as an event ending their participation in paid employment. A return to paid employment once children are at school is generally accepted as normal, and working/studying mothers are quite common. Upon re-entering the workforce many seek a more challenging occupation but may experience difficulty in finding a suitable job or training (Park, 1991:136). Overall, the women in their forties have benefited most from the marked social changes which have occurred within New Zealand since the Second World War and this is reflected in their education, marriage and employment patterns (see Davey, 1993:105-137).

It is evident that the tradition of taboo and stoicism so influential in the experience of the two oldest age groups, although still discernible, is being superseded by medicalisation as the dominant social mechanism of menopause control. Indeed, the developing impact of the medicalisation of menopause which emerged as a feature of the experience of women in their fifties, is clearly evident in the knowledge, attitudes and practice of those in their forties. The extent of the impact of medicalisation on the women's experiences can be identified through examination of some of the hallmarks of this process.

Lock (1995:xxv) points out that scientific investigation of the nature of physical decline and death is a recent reaction to demographic changes involving the ageing population in the industrialised Western nations during the second half of this century. Scientific recognition of ageing as 'an ongoing, genetic programme that starts early in the life cycle' has informed medical understanding of menopause as a process of depletion of ovarian follicles which commences before birth (Lock, 1994:xxv). Viewed in this way, menopause represents the culmination of a gradual process which spans approximately the first two-thirds of a woman's life and continues to impact on her remaining years. In other words, as a state of 'ovarian failure', menopause signals a

loss of 'female' hormones and the end of fertility which in turn are diagnosed as symptoms of ageing and decrepitude.

Instrumental in popularising the association of menopause with ageing was the promotion of oestrogen replacement during the early 1960s by Wilson. Wilson's view of post-menopausal women as in a state of 'living decay' (Wilson and Wilson, 1963, cited in Voda, 1993: 163), reinforced both medical verification of menopause as a symptom of old age and stereotypical views of older women as 'sexless hags' who had outlived their 'useful' reproductive years. Against such a background, that was part and parcel of their common sense knowledge, it is not surprising that the women in their forties expressed trepidation over the onset of menopause, maintained a perception of being 'too young' for this life-stage, and reported reactions of horror and disbelief when the first signs were detected. At best, the onset of menopause appeared to offer only a release from menstruation, but otherwise signalled loss, crisis and marginalisation, as suggested by Sheehy (1993: 51):

As a woman looks ahead to 'the change', it is natural to focus entirely on the loss of powers one has taken for granted in previous stages. The youthful looks you could always trade on, and the magical powers of procreation that connected you to the cycle of all life - suddenly, in the mid-forties, one must face that these powers are ebbing. What will replace them?

The point is, that the negative association of menopause with ageing exemplifies the ability of the process of medicalisation to both endorse and recast popular perceptions of bodily processes and functioning. As a socially constructed knowledge, the biomedical construction of menopause as the cessation of ovarian functioning complements, confirms and is incorporated in common sense views of menopause as 'a natural, normal life-stage' associated with ageing. However, the biomedical construction also presents menopause as a marker of the onset of physiological degeneration that is alarming to women in a youth orientated culture that values female attractiveness, sexuality and fertility.

Consistent with the process of medicalisation was an increase in the awareness and incidence of worsening PMS as a precursor to menopause. The women's familiarity with the 'condition' of PMS together with their use of the term to convey subjective

bodily experience, exemplifies the incorporation of a medical concept into the vernacular and associated lay reconceptualisation of bodily functioning. Popular recognition of intensifying PMS as a precursor to menopause carries with it an important implication. Kaufert and Gilbert (1986:10) point out that the biomedical construction of menopause as a permanent state of oestrogen deficiency has extended the temporal boundaries of this event from the last menses to the remainder of the female life cycle. The risk now is that popular recognition of PMS as a precursor to menopause, together with the potential for management of PMS with oestrogen therapy, will further extend the boundaries of menopause (see Studd and Panay, 1997:386). That is, extend the boundaries from an event once viewed as occurring at mid-life to one potentially affecting over two-thirds of a woman's adult life.

The impact of medicalisation was also evident in those incidents where the doctor did not accept the woman's judgement of being at menopause, particularly if she demanded a blood test to verify her perception. Kaufert (1986:72) argues:

...a woman 'knows' when she is menopausal. This knowledge is the product of a woman's awareness of changes as they take place within her own body; therefore, by this definition, the ability to classify a woman as menopausal becomes the exclusive property of the individual and is based on self-knowledge.

The difficulty is that medicalisation is accompanied by a devaluing of the knowledge and skills held by non-professionals, together with a general disregard for lay knowledge, opinion and judgement on matters related to health. In a situation such as that detailed above, the process of medicalisation operates on two levels: first, through the doctor's disregard of the woman's expertise about her own bodily functioning; and second, through the woman's deferment of her subjective wisdom to scientific verification of her menopausal status. Moreover, the confidence of women in the ability of doctors to effectively control their symptoms and monitor treatment side-effects further illustrates lay recognition of medical professionals as the custodians of specialised knowledge concerning the diagnosis, treatment and prevention of menopause-related symptoms.

The above examples illustrate those areas where the medicalisation of menopause has had maximum impact and in some cases has effectively reshaped perceptions and experience of this event. However, given the attitudes and practices of the women in

their forties, it would be an overstatement to claim that their menopause has been medicalised. Rather, it appears that a legitimate aspect of the process of medicalisation involves individual and collective resistance to medical control of the body. A determination to 'control' or 'regain control' of the body through processes of self-regulation, displayed by the women in their fifties, was even more marked among those in their forties. A quarter of those in their forties were determined not to use HRT, while a further third terminated treatment with HRT in favour of alternative strategies of symptom management. Although the women's rejection of hormonal management of menopause reflected a range of personal views and circumstances, there remained an overriding concern about the use of 'chemical' or 'unnatural' substances in the body and the risk of side-effects associated with hormone treatment.

MacPherson (1993:146-148) identifies three stages associated with the promotion of hormone treatment for the management of menopause as a deficiency disease. The first two occurred between the 1960s and mid 1970s when oestrogen was promoted as a 'youth pill' and panacea for a symptom-free menopause, respectively. During this period, sales of the drug tripled in North America only to decline in reaction to the publication of four studies in the *New England Journal of Medicine*, studies which linked oestrogen therapy with endometrial cancer. In the early 1980s, the addition of progesterone to oestrogen treatment in response to the risk of endometrial cancer signalled the onset of the third and current stage. Since the early 1980s the emphasis has been on the promotion of HRT as a protection against chronic degenerative diseases. The result is (MacPherson, 1993:148):

A current dominant trend...[which] link[s] osteoporosis to menopause as a strongly contributing, if not, leading casual factor. HRT is then presented as a logical and scientific choice to prevent or treat osteoporosis.

At the beginning of the 1990s, treatment with HRT was again linked with an increased risk of cancer, this time of the breast. The ensuing controversy in both the medical and popular literature regarding the benefits and risks of long- and short-term use of HRT has yet to be resolved. Opponents, such as Coney (1993: 173), point out the 'oversimplification' of the benefits of HRT as a protection against degenerative diseases, and warn that adverse effects are 'ignored, 'trivialised' or the unknown is 'simply not mentioned' (Klein, 1992: 24). Coney also points to local media promotion

of HRT as ‘the menopause miracle pill’, essential if ‘happiness, sexuality and physical well-being’ of the mid-life woman is to be ensured.<sup>32</sup> In the medical literature, however, the debate is not clear-cut. The 1995 publication of results from the Nurses’ Study in the *New England Journal of Medicine* identified a modest increase in breast cancer among post-menopausal nurses after five years of oestrogen treatment (Colditz et al., 1995). This finding stimulated intense and ongoing debate on the pros and cons of hormone therapy, involving groups such as the Australian Menopause Society (1995) which claimed:

Hormone therapy is safely given short-term (for up to five years) for the treatment of menopause-related symptoms and long-term, where indicated to reduce the risks of heart disease and osteoporotic fractures.

Alternatively, researchers such as Foidart et al. (1997:463) offer a more cautious view:

It is uncertain whether the modest increase in the risk of breast cancer with hormone use found in some epidemiological studies reflects a causal association or the influence of one or several forms of bias. Even more conflicting data are produced with respect to ever, recent and long-term use of combined therapy.

Within New Zealand, the National Advisory Committee on Core Health and Disability Support Services (1993b: 6), reporting on HRT, concluded:

Long-term use of HRT [is] not recommended for routine use in well women who are not at high risk of osteoporotic fracture or CHD [coronary heart disease]....it would be inappropriate to recommend to the majority of peri- or post-menopausal women any long-term prophylactic drug treatment that had not been studied extensively in large randomised trials of efficacy and safety (as measured by mortality and morbidity).

Against such a background, it was not surprising that many of the women expressed concern or unease over the prospect of treatment with HRT and the desire to retain or regain control of their body. Many were aware of the issues raised by Coney (1993) and none appeared to be concerned over the possible risk of long-term health problems associated with hormonal decline. Moreover, those taking HRT did so for the control of unpleasant or debilitating symptoms; that is, their treatment strategy choice was made on the basis of an immediate quality of life need rather than for prevention of long-term symptoms.

The limited impact of the deficiency disease construction of menopause on the views and strategies of the women in their forties can be largely attributed to two factors.

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<sup>32</sup> See Mackenzie (1990:101) and Donaldson (1991:28-29).

The first involves the tendency to present the deficiency disease view 'as if it were a direct representation of the full reality of the menopause experience rather than being simply an abstract entity' (Kaufert and Gilbert, 1986: 9). O'Leary Cobb (1994: 526), writing of the experience of Canadian women, makes the point that women do not perceive osteoporosis as a personal threat. She argues that it is only within the last ten years that women have been informed of the 'danger' of degenerative conditions such as osteoporosis. During this time, drug and dairy company campaigns have ensured that most women are aware of the benefits of lifestyle and dietary measures in offsetting any risk. In other words, if a woman doesn't perceive herself to be at risk she is unlikely to take preventative treatment.

The second point concerns the deficiency disease model emphasises on what Martin (1987: 43) identified as the failure of the 'authoritative structure' of the body, and Coney (1993:173-174) defined as 'designer menopause'. The outcome is a situation of Hobson's Choice for women concerning the management of menopause. Martin (1987: 43) explained:

One woman I talked to said her doctor gave her two choices for treatment of her menopause. She could either take estrogen and get cancer or she could not take it and have her bones dissolve.

Aside from being simplistic, the choices present an essentialist view of women as victims of their biology and overlook the fact that most women pass through menopause without much difficulty. Certainly, among all the women in the current study only five of the forty-seven who experienced a natural menopause reported very severe symptoms.<sup>33</sup> In response to the findings of a number of northern hemisphere studies, Davis (1989:52) argued that:

Although the experience of menopause appears to have some short-term effects on reported health (primarily limited to expected increases in menstrual flow problems and hot flashes and sweats) this was not of the magnitude predicted by medical models.

In short, the deficiency disease model of menopause was limited in its appeal to the women in their forties because it presents an abstract, extreme and remote view which has little bearing on their lived reality.

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<sup>33</sup> Five of the fifty-two women who identified themselves as 'in' or 'through' menopause experienced a surgical menopause.

The last word, however, lies with O'Leary Cobb (1994: 529) who found that among Canadian women the most difficult aspect of menopause was:

...a woman's loss of control....many women regard it as common sense to look first to gentler remedies - healthier foods, more exercise, perhaps herbal teas or vitamin and mineral supplements....they do offer the option of personally controlling the amounts used, of charting gradual improvements, and thus of managing one's own menopause.

In common with Canadian women, it was the desire of women in their forties to retain or regain control that appeared to be the ultimate determinant of their choice of strategy for the management of menopause and its symptoms. The comments of those who elected to manage symptoms with self-help strategies indicate a sense of self-fulfilment, confidence and satisfaction at having 'coped' unaided. Such comments are not dissimilar to those made by a number of the older women. The difference for the women in their forties, however, is that they are in a better position to choose their preferred strategy for control of the menopausal body now that the impact of taboo and stoicism has diminished.

## CONCLUSION

The expectations, experience and reflections of the fifty-two women who defined themselves as 'in' or 'through' menopause reveal a number of age group similarities and differences. There is, for example, considerable similarity between the experiences of the women in the two oldest (seventy and over, and sixties) age groups and likewise among those in the two youngest (fifties and forties) age groups. Over the four age groups, however, the impact of changes in social attitudes, women's role and position in society and medical knowledge are reflected in the women's changing common sense understandings and knowledge of menopause and hence their changing perceptions and experience of this event. Finally, it may be noted here that there were no obvious or readily discernible differences within each age group in the experience of women from the Feilding-Manawatu district as compared with that of *New Zealand Woman's Day* respondents residing elsewhere in New Zealand.

Control of the menopausal body emerged as the central aspect of each woman's experience. As a manifestation of the body politic, the dominant mechanisms of control exemplify prevailing social views and medical wisdom. Accordingly, the experience of menopause among the women aged sixty and above was dominated by the requirement

of socially imposed, individual control of the body through the strategies of taboo and stoicism. The latter was typically manifest through the attitude that at menopause a woman should 'just get on with it'. In contrast, the experience of the two younger age groups was dominated by the process of medicalisation which permeated their common sense understandings and knowledge, and redefined menopause as a deficiency disease in need of professional management and control.

In contrast with the older women, those in their fifties and forties reported experiencing and/or attributed a much wider range of symptoms to menopause. This change appeared to be associated with the breakdown of the taboo and the promotion of HRT, both of which contributed to discussion and the sharing of experience and information, thereby broadening the common sense knowledge base. One of the new symptoms signalling the onset of menopause was PMS, a syndrome unrecognised among the two older age groups but increasingly reported by the younger women. Familiarity with the condition of PMS and use of the term to describe bodily and behavioural changes exemplified the process of medicalisation. In particular, it was argued that popular recognition of PMS as a precursor to menopause, and its potential management with oestrogen therapy, risks extending the boundaries of menopause from an event of mid-life to one affecting two-thirds of a woman's adult life.

The impact of the mechanisms of control of the menopausal body were apparent in a number of ways. Among the two older age groups the requirement of taboo and stoicism was associated with a paucity of shared experiential knowledge and a risk of social sanction if control of the body was not maintained. For these women, the symptom management strategy choices were limited and although some were being treated with HRT, most relied on hard work, a positive mental outlook and lifestyle adjustments. By the time the women in their fifties and forties reached menopause the dominant requirement of taboo and stoicism was being overtaken by medicalisation, although the refusal or reluctance of mothers to discuss the subject with their daughters perpetuated some aspects of the tradition of taboo. As a result, the two younger age groups approached menopause with a wider range of knowledge than the older groups and had a greater variety of strategies for the control of symptoms at their disposal. The increasing popularity of HRT, however, was offset by a noticeable

disquiet among the women over the implications of a medicalised menopause. The outcome, strongly indicating the ability of women to act as self-determining agents, was the employment of a range of complementary 'natural' strategies for the management of symptoms.

Overall, the women perceived menopause as a natural life-stage with most feeling ambivalent or negative about their experience. Among the younger women there was a negative association of menopause with ageing, with those in their forties commonly feeling that they were 'too young' to be at this life-stage. Finally, embarrassment at the possibility of symptoms being apparent in public was common across all age groups and signalled both the women's desire and the social pressure to control the menopausal body. In other words, the women's experience of menopause was primarily shaped and constrained by the body politic.

## Conclusion

Notions about the individual body and the body politic permeate theories which construct the ideological reality within which the subject comes to be gendered, inhabiting a body whose biological and sexual manifestation are coded in specific ways at specific times.

Jacobus et al. (1990:2)

This thesis has focused on attitudes towards and the expectations, perceptions and experience of menopause among women aged thirty years and above residing in the Feilding-Manawatu district and elsewhere in New Zealand. The aim was to explore the social construction and individual experience of menopause within the New Zealand context, while the four specific objectives guiding the research were:

- to identify and examine the significance of wider social forces on women's perceptions and experience of menopause;
- to explore the impact of the deficiency disease model of menopause on women's perceptions, understanding and experience;
- to identify past and current attitudes, common sense knowledge, myths and expectations towards menopause;
- to establish whether or not there are age group differences in women's experience of menopause.

The prime rationale for this investigation was to address the paucity of social research on New Zealand women's experience of menopause in order to contribute to an understanding of this event for women such as myself (the post-war baby boomers) who are currently reaching menopause.

### **LITERATURE REVIEW AND THEORETICAL PERSPECTIVE**

In order to background the subject and identify an appropriate theoretical perspective, the thesis began with an overview of recent popular and academic literature on menopause (Chapter 1). The popular literature identified the emergence of the disease model of menopause in the mid 1960s (Wilson, 1966) and the resulting tension between this model and the normal, natural life-stage view of this event. Resistance to the deficiency disease model, and the potential medicalisation of menopause, was

evident in the lifestyle strategies for the management of menopause advocated in self-help manuals.<sup>1</sup> Similarly, the emphasis placed by popular critical accounts on menopause and mid-life as a time of change, and their emphasis on the politics of HRT, indicated a rejection of the disease model of menopause.<sup>2</sup>

In the introduction to the edited proceedings of *The 8<sup>th</sup> International Congress on the Menopause*, Sydney, November 1996, Wren (1997: 5-6) noted that:

Today we recognise menopause to be a time of normal physiological change often coinciding with a changing family - or work - environment. The menopause transition is extremely variable within and across cultures. The complexity of hormonal, psychosocio-cultural and aging factors produces a varied symptomology and long-term health outcomes. Consequently, untangling the relationship between menopause, aging, disease and behavioural change has been plagued with methodological difficulties.

Wren's comments are significant because they address the same issues raised by the popular literature. His comments recognising menopause as 'a time of normal physiological change' that often coincides with other changes in the life of women, intra- and cross-cultural variations and the 'varied symptomology' of this event, are welcomed. As an endocrinologist and founding president of the Australian Menopause Society, however, Wren's identification of the methodological difficulties associated with 'untangling the relationship between menopause, aging, disease and behavioural change' is quite another matter. It reflects the predominantly biomedical focus of menopause research which employs realist methodologies in the expectation of identifying linear, causal relationships. An assumption of the biomedical model is that realist methodologies represent the only valid way of explaining and understanding phenomena. The position taken in this thesis, on the other hand, is that the limitations of realist methodologies need to be acknowledged and that new alternative and *complementary* relativist approaches need to be developed.

A critical examination of the academic literature on menopause published since 1980 identified three theoretical orientations that have been graphically illustrated via a qualitative factorial analysis (see Figure 1.1). These orientations were the

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<sup>1</sup> See, for example, Potter (1991).

<sup>2</sup> See Sheehy (1993), Greer (1992) and Coney (1993).

biomedical/positivist, humanistic/interpretive and constructivist/critical perspectives. It was pointed out that the majority of the publications on menopause conform to the biomedical/positivist classification. Underpinning this orientation are realist assumptions with respect to the unmediated nature of scientific knowledge and an emphasis on documentation and quantification of clinical and lay attitudes, knowledge, management and practices associated with menopause. In contrast, three-quarters of the humanistic/interpretive orientation and all of the constructivist/critical orientation fell within the relativist paradigm wherein phenomena are viewed as the product of complex relationships (see Figure 2.4). The focus of the three segments of the humanistic/interpretive orientation located within the relativist paradigm is on explanation and understanding of the meaning of the actions, practices and experiences among individuals and groups. Additionally, the constructivist/critical orientation addresses the interplay between received wisdom, existing social structures and institutions on the one hand, and social, economic and historical processes and collective human activity on the other.

The blurred boundary at each interface of the three perspectives was identified as presenting a theoretical area which avoided the excesses of 'purer' forms and promised a degree of theoretical flexibility. The location of the interface of the humanistic/interpretive and constructivist/critical approaches within the relativist paradigm, together with their combined emphasis on explanation and meaning and focus on the impact of wider social processes, identified a constructivist/interpretive orientation as the most appropriate theoretical perspective for this thesis (see Figure 2.5). The advantage of a constructivist/interpretive orientation is its ability to facilitate exploration and explanation of women's perceptions and experiences of menopause within the context of socio-cultural forces. From this perspective, models of menopause are recognised as culturally constructed and normative views of the feminine are acknowledged as fundamental to social perception and individual experience of menopause. Finally, the constructivist/interpretive orientation facilitated a critical investigation of the impact of the biomedical construction of menopause as a deficiency disease.

## **HEALTH PROFESSIONALS AND EDUCATIONAL MATERIAL**

In order to situate the issues and arguments identified by the literature review within the New Zealand context, the focus of Chapters 3 and 4 was on the views of health professionals and the content of locally available educational programmes and material. Chapter 3 examined the views of a local group of general practitioners and of Australasian specialist consultants on menopause and its clinical management. This examination was primarily directed toward the attainment of the first and second objectives specified for this thesis, namely:

- to identify and examine the significance of wider social forces on women's perceptions and experience of menopause;
- to explore the impact of the deficiency disease model of menopause on women's perceptions, understanding and experience.

The discussion identified a polarisation between the general practitioners and specialist consultants in terms of their perceptions of menopause as a normal, natural life-stage and as a deficiency disease, respectively. It was found that the life-stage view advocated by the general practitioners reflected their personal and clinical experiences. For six of these practitioners, the nature of their patient base, time constraints and relative inexperience in the management of menopause contributed to their perception of a lack of clear guidelines on the diagnosis and treatment of menopause. As a result, the practitioners overlaid medical knowledge with personal experience and developed clinical consultation strategies which they thought would minimise the possibility of adverse treatment outcomes. In contrast, the two remaining (female) practitioners, who had considerable clinical experience in the area of women's health, expressed confidence in their ability to successfully diagnose and treat menopausal symptoms. Although they shared their colleagues' view of menopause as a normal life-stage, their professional clinical experience meant that they were open to the notion of menopause as a health hazard. Both of these practitioners consequently advocated the medical management of menopause through treatment with HRT, but like their colleagues followed a practice of informed patient choice. In this respect, the strategies employed by the practitioners for the management of menopause challenge the claim of Morse et

al. (1994:171) that 'throughout the world, HRT is offered quite indiscriminately to middle-aged women seeking help'.

In contrast to the general practitioners, the specialist consultants perceived menopause as a deficiency disease and advocated its medical management with HRT. Underpinning the views of this group were both their specialist training and extensive clinical experience. It was suggested that the specialists' confidence in the benefits of the management of menopause with hormone treatment was affirmed by the apparent congruence between clinical research results and clinical practice outcomes.

There are both similarities and differences between these findings and those of Lock (1982) with respect to a group of Canadian clinicians. The first similarity concerned her identification of two conflicting models of menopause, one of which - the deficiency disease model - is obviously congruent with the model adopted by the Australasian specialist consultants and recognised by the general practitioners. On the other hand, the biopsychosocial model identified by Lock, emphasised the social and psychological aspects of menopause rather than its significance as a normal life-stage transition for the general practitioners in this study. The different emphasis may be explained by the interval of sixteen years since Lock's study and the different socio-cultural contexts within which the clinicians operate. A second similarity related to Lock's (1982:269) finding that clinical views and decisions were influenced by non-medical factors such as personal attitudes, social circumstances, professional training, access to educational resources and the nature of the patient population. This was confirmed through the comments of the general practitioners in this study. Finally, knowledge difficulties identified by the general practitioners confirmed Lock's (1982:269) argument that a lack of medical consensus on the true signs and symptoms of menopause and the enormous variation in biological events generated confusion and ambiguities over the exact nature of menopause and its treatment.

In the course of examining the views and experience of the general practitioners and specialist consultants, two key issues emerged. The first was the link between science

and medicine. It was argued that the mechanistic, dualistic assumptions of science promote the separation of mind from body and an emphasis in biomedicine on physiological processes and cause/effect relationships. The implication, in terms of the objectives for this thesis and more specifically for women experiencing menopause, is that the biomedical focus will be on ovarian activity and associated hormonal decline rather than the social, cultural and personal aspects of this event. Second, it was noted that biomedical redefinition of menopause as a deficiency disease was made possible by the scientific identification of sex hormones and the development of hormone therapy. Here a link between culture, science and medicine was evident in terms of both Victorian recognition of the uterus as the essence of femininity and the impact of essentialist notions of the masculine and feminine on the process of scientific identification of sex hormones. The consequences were far-reaching: a normal life-stage was converted into a pathological disorder; the 'flawed woman' ideology was advanced; and confusion was fostered over the application of HRT as either a disease prevention strategy or a disease treatment strategy. Finally, with menopause redefined as a disease of oestrogen deficiency which required expert monitoring and management, the way was paved for medicalisation of this phenomenon.

Chapter 4 examined a selected range of menopause educational material and programmes, and the responses of a group of Feilding-Manawatu district women to selected videos and audio-tapes. The aim, in accord with the first two objectives specified for this thesis, was to identify the perspectives on menopause presented in selected educational artefacts so as to better understand and explain the women's views and experiences. Content analysis of the selected artefacts identified both their manifest and latent content. It was found that educational resources produced by medically orientated groups such as pharmaceutical companies adopted a deficiency disease view of menopause whereas those produced by 'independent' groups or organisations presented a life-stage approach. At the level of manifest content, indicators of an artefact's orientation to menopause emerged through the use of key words and/or the type of management strategies advocated. For example, pharmaceutical company artefacts emphasised the physiology of menopause through

the use of words such as 'hormone' and 'osteoporosis', and promoted medical management with HRT. In contrast, the 'independent' material emphasised words such as 'sleep disruption' and 'tiredness' and promoted lifestyle management strategies such as diet and exercise. Identification of the latent content of each artefact revealed the philosophical perspective. For example, the New Zealand Family Planning Association workshops affirmed the ability of mid-life women to act as self-determining agents.

In the final section of Chapter 4 the responses of a small group of Feilding-Manawatu district women were obtained to selected educational videos and audio-tapes. Their responses were generally consistent with the findings of the content analysis, although in two cases the programmes were identified as presenting both the deficiency disease and life-stage perspectives. The women's juxtaposition of the two orientations was interpreted as an indication of the dominance of a pathological (i.e. deficiency disease) understanding of menopause.

Overall, the latent content comprised a range of mixed messages presented to the target audience. Women were exhorted to take responsibility for their long-term health through the use of HRT; encouraged to take 'control' of their lives through implementation of lifestyle changes and self-help strategies; and warned of the dangers of the medicalisation of menopause and its commodification through HRT. On the basis of the material examined, it could be argued that women are confronted by a virtual 'information maze' and so are at risk of developing the same confusion and uncertainty towards menopause exhibited by the majority of the general practitioners (see Chapter 3). The women's juxtaposition of both orientations in response to two of the selected artefacts was suggestive of the knowledge ambiguities exhibited by the general practitioners who viewed menopause as a life-stage but implemented clinical strategies associated with the deficiency disease perspective. It appeared that while the women viewed menopause as a normal life-stage, their perceptions were overlaid by the deficiency disease view; that is, their responses reflected the influence of the process of medicalisation on popular views of this event. Koster's (1991:11) study of Danish women reached a similar conclusion. In this case, Koster's respondents

regarded menopause as both a 'physiological process' (i.e. a female life-stage) and as a 'condition requiring medical attention'.

### **MENOPAUSE KNOWLEDGE**

The nature and extent of knowledge of menopause among the women in the study was the focus of Chapter 5. The aims were to establish the existence of social constraints surrounding discussion of menopause and to identify the main sources of knowledge. Mother/daughter and woman-to-woman communication, in addition to the women's assessment of their knowledge status and views on the quality and availability of information, were therefore examined in accord with the second and third objectives of this thesis, that is:

- to explore the impact of the deficiency disease model of menopause on women's perceptions, understanding and experience;
- to identify past and current attitudes, common sense knowledge, myths and expectations towards menopause.

The presence of a taboo surrounding social discussion of menopause was identified. Most Feilding-Manawatu participants and *New Zealand Woman's Day* respondents reported difficulty in raising or discussing the subject with their mothers and noted that attempts to do so were commonly met with either an outright refusal or hampered by reticence or inhibition. This finding was very similar to the situation described among North American women by Sheehy (1993:26). Consequently, most of the women had little insight with respect to their mothers' experiences although some held clear memories of their mother and/or other mid-life women experiencing symptoms such as hot flushes and flooding. Others, with hindsight, attributed observed maternal behavioural changes, such as temper tantrums or prolonged periods in bed, to menopause. Such memories and observations were frequently overlaid with recollections of oblique, whispered references to 'the change' in conjunction with gossip about local women exhibiting strange behaviour or entering mental institutions.

The presence and impact of a taboo was most apparent among the older women (those over sixty) who commonly reported that their peers neither raised nor discussed menopause. Similar observations were made by a number of the younger women although this was not always the case. It seemed, for example, that in the workplace menopause was talked about, albeit in a superficial manner and often as the source or subject of humour. Overall, the women's comments indicated that although the influence of the taboo surrounding social discussion of menopause had eased considerably for those in their forties and fifties, it had by no means disappeared.

In light of the taboo it came as no surprise that few of the older participants (aged sixty and above) identified other women as important sources of knowledge on menopause and that there was a paucity of shared, experience-generated common sense knowledge among them in comparison with those under sixty years of age. Moreover, remnants of the taboo (in the form of embarrassment or fear of being 'labelled') appeared to account for the fact that very few of the younger women either knew about or had attended menopause educational programmes. It could also be argued that the tradition of taboo was reflected in the identification of printed material and particularly popular women's magazines as the most common source of information. Women's magazines are able to address the socially unmentionable and offer seemingly common sense information in a manner that allows anonymous access to personal accounts of menopause experience. A danger with this type of information, however, is that it tends to present and highlight the unusual, extreme and sensational, thereby promoting a view of menopause as a negative event which requires medical management.

With the exception of those with a nursing background, most participants and respondents (irrespective of their age) possessed only vague knowledge of the physical process of menopause. Very few, for example, had any idea as to the nature, role or function of a hormone. Despite such limited knowledge, the term 'hormone' was commonly used by the women to describe, explain and account for events associated with menopause and female sexuality. In other words, as a classic illustration of the

impact of the process of medicalisation, a medical concept had merged with common sense knowledge and facilitated a reconceptualisation of bodily functioning.

In general, the women indicated dissatisfaction with the quality and quantity of the available information on menopause. They typically assessed material such as articles in women's magazines as superficial but complained that the medically orientated information was too technical. Their comments identified an ambivalence between a desire for subjective, experience-generated knowledge (such as that presented in the popular magazines) on the one hand, and medically authenticated 'facts' (as presented in books, pamphlets and educational workshops) on the other. Compounding the situation was the tendency to privilege medical 'facts', a tendency illustrated by the dismissal of certain magazine material as 'junk' and 'rubbish'. As a result, many felt that much of the currently available information failed to address their personal situation. In many respects these findings are similar to Duncan's (1995:106) conclusions concerning the need for balanced, easy to read information that allows women to assess their own expectations and experiences against those of other women.

The vagueness of the study participants and respondents as to the physiology of menopause and their dismissal of much medical information as 'too technical' was possibly indicative of their age and educational backgrounds but may signal an inability to fully identify with the medical explanation of menopause. An implication is that the women desired only the knowledge that they perceived as personally meaningful. In some situations their needs were met by popular magazines, pamphlets and books, while in others medical concepts took on more immediate relevance and meaning.

Finally, the women's views on the quality of menopause information were in many respects similar to those of the general practitioners. Like the general practitioners, the women were confronted by seemingly contradictory views of menopause. One view, perpetuated through the tradition of taboo and associated stoicism, emphasised menopause as a normal female life transition which did not require prior knowledge or

specific management strategies. Redefined as a deficiency disease, however, a second view presented menopause as a time of physiological change and associated health risks which required the knowledge and use of effective medical management strategies.

The significance of the above points lies in the fact that the common sense knowledge of these women (with all its strengths and shortcomings) plays a major role in shaping and informing their expectations, perceptions, meanings and experience of menopause. In these terms, as became evident in subsequent chapters of this thesis, their encounter with menopause would often be made more difficult because their knowledge was eclectic, disjointed, inherently contradictory and privileged one source over others. Drawing on a range of sources, and varying in content between older and younger women, their knowledge was disjointed in the sense of not forming an integrated whole. It encompassed positive and negative stereotypical beliefs as well as scientifically established physiological processes and was fraught with contradictions reflecting the accommodation of the life-stage and deficiency disease models. The tension between these two competing constructions of reality was evident in the privilege accorded to medically orientated 'facts', a desired improvement in their level of understanding of the physiology of menopause and their parallel need for experience-based, subjective understanding of this life passage.

## **THE MEANINGS OF MENOPAUSE**

Chapter 6 had two aims: first, to establish the meanings of menopause through examination of the women's attitudes, perceptions and expectations; and second, to explore those factors which influence the formation of the women's views. These aims, tackled via the themes of mid-life and ageing, loss of fertility, and health risk, were in accord with the first three objectives of this thesis:

- to identify and examine the significance of wider social forces on women's perceptions and experience of menopause;
- to explore the impact of the deficiency disease model of menopause on women's perceptions, understanding and experience;

- to identify past and current attitudes, common sense knowledge, myths and expectations towards menopause.

Underpinning each of the three themes (mid-life and ageing, loss of fertility, and health risk) was the impact of the body politic. Central to the association of menopause with mid-life and ageing, the body politic shaped the women's perception of menopause as a 'natural' event, their expectation of stoic endurance of symptoms and evolutionary explanations of the end of female fertility. Informing the view of menopause as 'natural' were the essentialist assumptions of medical science and normative definitions of the feminine, both of which were manifest in the recognition of menopause as physiologically and socially deviant. Perceived as a natural life-stage associated with the process of ageing, many of the women conveyed the expectation that at menopause they would 'just get on with it'. Moreover, particularly in the case of the older women, it was clear that those who failed to stoically endure menopause-related problems risked being regarded as socially deviant. Similarly, the notion of menopause as physiologically deviant emerged through references to male jokes and the 'put down' of menopausal women on the basis of their hormonal decline and status as an enigma in the process of human evolution. In other words, the hegemonic influence of medical science promoted the association of menopause with mid-life and ageing primarily through the assumption of the standard of the 'unmarked male'.

Among a small group the loss of fertility was a time of sadness and closure that carried with it a sense of powerlessness in the face of biological determinacy. Most of the women, however, regarded the end of fertility as a positive event which liberated them from menstruation and, in some cases, the fear of pregnancy. But viewed in the context of a youth-orientated culture, the loss of fertility at menopause signified ageing in addition to diminished attractiveness and femininity. As a result, stereotypical views of female ageing emerged through unfounded fears that once through menopause they would become 'dried up, wrinkled, old hags'. The discussion also identified the women's awareness of behavioural changes in their husbands, changes that the women attributed to 'male menopause'. It was suggested that this perception signalled their

rejection of both the biomedical assumption of the 'universalised natural body' and an associated view of female reproductive physiology as deviant.

Finally, the view of menopause as a health risk was rejected by the majority of the women. This finding appears to be consistent with those of Koster (1991). Danish women, although recognising menopause as a 'condition requiring medical attention' (Koster, 1991:11), rejected the notion of 'the change of life' as an illness. Reinforcing their view of menopause as a positive, natural event was common sense knowledge and the associated traditions of stoicism and taboo. In common with respondents in the SROW (1988) study, a few expressed apprehension over their ability to cope with embarrassing and/or inconvenient symptoms. However, most of the women regarded menopause as uneventful and, in some cases, as a health benefit once they were free of menstruation and childbearing. As a result, they were generally unreceptive to or held strong reservations about the benefits of long-term treatment with HRT as a health promotion strategy. That said, it is acknowledged that there was a small group whose doubts about the risks associated with HRT were overridden by their immediate need for relief from often severe and unpleasant symptoms.

Overall, the women's attitudes, perceptions and expectations of menopause were informed by both common sense knowledge and medical knowledge of this event. Common to both was the impact of the body politic through the notion of deviance. As a consequence the women's comments presented a view of menopause as a normal, natural life-stage overlaid with the assumptions of medical science (i.e. the deficiency disease state). It was clear, however, that the women were also in the process of incorporating medical knowledge associated with the deficiency disease model into their own common sense models of meaning. Although influenced by the process of medicalisation their emergent common sense models emphasised those aspects of the knowledge they deemed most meaningful and disregarded those aspects that were not. In this way the women demonstrated that they were not completely 'buying in' to the deficiency disease model and that they were resisting, in part at least, the process of medicalisation. This finding was consistent with that of Duncan (1995), who identified

resistance to the medicalisation of menopause among the women in her Wellington study; and Hamilton (1990), who found little evidence among Canterbury women to suggest they accepted the deficiency disease view.

## **EXPERIENCE ACROSS THE AGE GROUPS**

The focus of Chapters 7 and 8 was on the fifty-two women who defined themselves as 'in' or 'through' menopause. Chapter 7 presented sixteen representative narratives with the primary aim of providing a starting point for Chapter 8.

Focusing on women in four age groups (i.e. those aged seventy and over, and women in their sixties, fifties, and forties), the aim of Chapter 8 was to examine, compare and contrast their expectations of menopause, their experience of menopause (i.e. its onset and coping with symptoms) and reflections on menopause. This aim was pursued in accord with the fourth objective for this thesis:

- to establish whether or not there are age group differences in women's experience of menopause.

The reflections of the women aged seventy and above were examined first. For these women, menopause was a socially prescribed event which they remembered with ambivalence or negativity. Dominating their experiences was a legacy of Victorian attitudes towards female sexuality and colonial views on the role and status of women. These attitudes and views were manifest in the social requirement of taboo and stoicism. As might be expected therefore (quite apart from the dimming of memories over time), most held only vague memories of their experience of menopause, the 'ease' of which they generally attributed to hard work. The two women who did have problems associated their experiences with stressful personal circumstances as well as feelings of being socially isolated and misunderstood on account of their inability to 'just get on with it'. Their experiences conform to the finding of Greene and Cooke (1980:490) that 'the severity of [menopausal] symptoms is associated directly with the presence of a high degree of life stress'. Overall, however, among the women aged seventy and above the principal factor in their experience was the social expectation of

personal control over the menopausal body. Failure to conform meant that they risked being perceived as lacking in moral fibre or fortitude and therefore socially deviant.

The recollections of the women in their sixties signalled important changes in knowledge and social attitudes towards menopause and its management. Overall, this group viewed menopause as a positive, natural life-stage and, in contrast with those aged seventy and over, held clearer memories and were more forthcoming about their experiences. While still heavily influenced by the requirements of taboo and stoicism, the most notable change in experience involved the erosion of the notion of hard work as an antidote for symptoms in favour of alternative management strategies. For some women this involved entering the paid workforce (to keep the mind occupied) while others implemented lifestyle modifications. Additionally, and most significantly, one third of the group had received treatment with HRT for the relief of short-term symptoms. Consequently, the former perception of menopausal symptoms as 'a product of the mind' was challenged and the way paved for the medicalisation of menopause. In common with those aged seventy and above, however, the experience of menopause among the women in their sixties was primarily characterised by their desire to control the menopausal body.

The experiences of women in their fifties, the largest group in the study (the younger members of which were among the first of the post-war 'baby boomers'), reflected changes in the role and lifestyles of women that gathered pace in New Zealand from the 1960s onwards. For example, a number held responsible career positions and most were in the paid workforce. Although remnants of taboo and stoicism remained, the fact that most in this group were better informed and less inhibited in discussing their experience than the older women was possibly indicative of the impact of publicity surrounding the promotion of menopause treatment with HRT. However, the continuing influence of the tradition of stoicism was evident in the common attitude that an inability to 'get on with it' reflected personal weakness and/or an inability to cope.

In common with the two older age groups, the pressure and desire to control the menopausal body emerged as the main theme among the women in their fifties. In contrast with those in their sixties, they perceived any manifestation of menopause as an interference and embarrassment in their working lives but recognised that they could 'get on with it' with medical assistance for the control of symptoms. As a result, just under two-thirds of the group had or were receiving treatment with HRT.

Reflecting the impact of medical redefinition of menopause as a deficiency disease, the women recognised PMS as a precursor to menopause to which they also attributed a much wider range of symptoms. However, there were signs of their resistance to medicalisation. Some desired to proceed through menopause naturally, insisting that menopause was a normal, natural life-stage, and there was unease over the possible side-effects of HRT. Despite being better informed, and having access to a wider and more effective range of coping strategies, very few women in their fifties viewed menopause as a positive life-stage. In some respects the experience of this age group, coupled with the more positive perception of those in their sixties, appears to support Duignan's (1989) contention that medicalisation leads to negative perceptions of menopause. This is not to say, however, that negative stereotypes and common sense perceptions were non-existent prior to medical identification of menopause as a deficiency disease.

The experiences of the women in their forties, the youngest of the four age groups, provided the greatest contrast with those of the older women aged sixty and over. It was apparent that the former influence of taboo and stoicism was being superseded by the medicalisation of menopause. This phenomenon was evident through: an increasing emphasis, initially evident in the fifties age group, on PMS as a precursor to menopause; the reaction of many of the women that they were too young for menopause; and the demand by some for medical verification (laboratory testing) of their menopausal status. It was argued, however, that although the deficiency disease view had effectively reshaped the perceptions and experience of these younger women, it would be overstating the case to argue that their experiences had been totally

medicalised. Indeed, it was apparent that a number of them exhibited a noticeable determination to maintain or regain control of their menopausal bodies without hormone treatment and by the implementation of a range of 'natural' self-regulated strategies. In other words, they exhibited a backlash to medical control of menopause and in so doing indicated a new-found sense of self-confidence and satisfaction. This finding confirmed Dumble's (1992) argument that women come off HRT because they wish to 'regain' control over their bodies and symptoms, and it challenges the denial of women's agency implied by the argument that the disease model of menopause is being imposed on women through the promotion of HRT (Kaufert and Gilbert, 1986). Such an argument fails to take into account the diminished impact of taboo and stoicism that contributed to the ability of the women in their forties to make informed choices on the most appropriate strategies for the management of menopausal symptoms.

Finally, it is appropriate at this point to comment briefly on the results obtained from the two main groups of women involved in this study - the Feilding-Manawatu district group (the prime site for the investigation) and the respondents recruited from among readers of the *New Zealand Woman's Day*. My initial and persistent focus throughout this study has been on the women from the Feilding-Manawatu district, but the *New Zealand Woman's Day* respondents have provided an important opportunity to place and examine the views and experience of the Feilding-Manawatu women within a wider national context. It cannot be emphasised too strongly, therefore, that on the basis of the results presented in this study (notably in Chapters 5, 6 and 8) there were no immediate or obvious differences - aside from those related to their age group distributions - that could be discerned between the two groups of women in terms of their expectations, attitudes, perceptions and experiences of menopause. It could be argued perhaps that this finding is a reflection of the fact that the majority of the participants from the two groups were residents of provincial New Zealand and that their socio-cultural similarities (overwhelmingly non-Maori New Zealanders of European origin or descent) overrode differences in their occupational patterns and the occupations of their partners (see Chapter 2, Table 2.1).

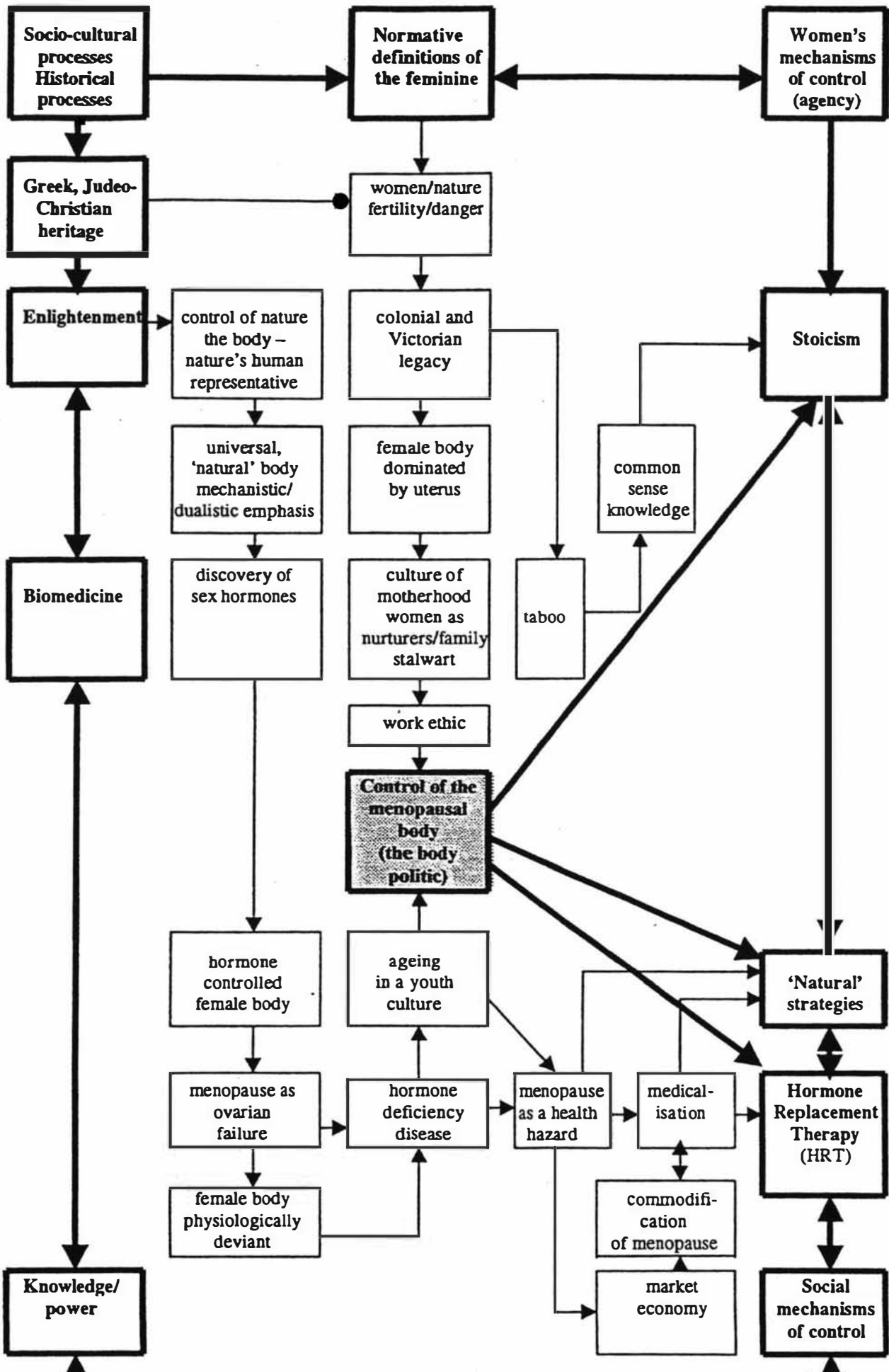


Figure 9.1: A constructivist/interpretive schematic integration of factors affecting menopause

## A SCHEMATIC INTEGRATION

The highly variable and complex nature of the menopause experience is evident in the narratives and responses of the fifty-two women in the four age groups examined in Chapter 8. Central to the experience of women in each age group was the impact of the body politic, manifest through their desire to regulate and control the menopausal body. As a powerful tool of social management, formed and constrained through socio-historical processes of power and control, the body politic safeguards the reproduction of social norms relating to corporeal appearance and actions (Haraway, 1991:7; Zita, 1993: 73). Employment of stoicism, ‘natural’ strategies and HRT as the three mechanisms of control of the menopausal body epitomised the complexity of socio-historical factors underpinning the experiences of each age group. The findings summarised in the preceding pages can now be integrated to illustrate the relationship and impact of diverse forces and processes upon control of the menopausal body and the mechanisms for management of women’s experience of menopause (see Figure 9.1).

Identification of *control of the menopausal body*<sup>3</sup> as the central aspect of experience is consistent with the constructivist/interpretive theoretical orientation adopted in this thesis. The argument was made in Chapter 3 that this perspective would facilitate a critical examination of the participants’ perceptions and experiences of menopause as a social construct, and the recognition of models of menopause as culturally constructed. Represented schematically in Figure 9.1, the major themes which emerge through the women’s attitudes, perceptions and experiences demonstrate the culturally constructed nature of this event. Underpinning the construction of models of menopause are a complexity of *socio-cultural* and *historical processes* and in particular the interrelated (although depicted separately for the sake of representational clarity) realms of *normative definitions of the feminine* and *knowledge and power*, respectively. As powerful instruments of the body politic, the demonstrated ability of each realm to

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<sup>3</sup> Words or phrases in italics identify particular components of Figure 9.1. This identification technique has been employed to assist the reader in linking the discussion with the diagram.

regulate, constrain and shape the physical manifestation and individual experience of the menopausal body has been a consistent theme throughout the thesis.

Turning to the impact of *historical processes* (see Figure 9.1) it was argued that throughout European history women's bodies have been perceived as a threat to the moral and social stability of society. The biblical origins of this perception, depicted in the fall of Eve, informed traditional *Judeo-Christian* views of women as morally weak, sexual temptresses and perpetuated the association of female fertility with *nature and danger*. Such views were commensurate with the *Enlightenment* emphasis on the control of nature and recognition of *the body as nature's human representative*. Moreover, scientific application of the principles of *Greek dualistic* and rationalist thought facilitated a *mechanistic* understanding of the universe and the human body. The development of *biomedicine* promoted a shift from moral to physiological control of the female body and essentialist explanations of the feminine.

Focusing on the *socio-cultural processes* informing cultural models of menopause, both the *colonial and Victorian legacies* are identified as influencing a social desire to control the menopausal body. The Victorian perception of the *uterus dominated female body* drew on earlier associations of *female fertility with nature* and the then current developments in medical knowledge. Overlaid with paternalism, moralism and cultural superiority, such a view promoted the social role of *women as nurturers* and the transmitters of social mores as well as a climate of indelicacy around the subject of female reproductive functioning. Consequently, the anomalous reproductive state of the post-menopausal woman represented a threat to social order. Within the colonial context, the vital social and economic contribution of women was ensured through a combination of Victorian social mores, the *culture of motherhood* and *work ethic*.

Returning to the realm of *knowledge and power*, Victorian essentialist explanations of the uterus as the regulator of femininity contributed to the *discovery of sex hormones* and identification of the *hormonally controlled female body*. This discovery allowed menopause to be recognised as a pathological condition of *ovarian failure*, and

fostered the view of the menopausal body as *physiologically deviant* against the standard of *youth* and the 'unmarked male' and facilitated the medical identification of menopause as a marker of *ageing*. More significantly, it redefined menopause as a *health hazard* in need of medical management and control. As these developments occurred within a *market economy* at a time of demographic change with an ageing 'baby boomer' population, there was also the potential for both the *medicalisation* and *commodification* of menopause.

Within the framework of socio-cultural and historical processes (including the realms of knowledge and power and normative definitions of the feminine) the *body politic* is manifest in *both* individual and social mechanisms of control. Moreover, although no one strategy was exclusive to a particular age group, the shift in emphasis from *stoicism* (among women aged sixty and over) to *HRT* and '*natural*' strategies (for those in their fifties and forties) reflected a changing social context and developments in medical knowledge.

Looking at Figure 9.1, it is evident that driving each of the three mechanisms of control is a complex set of dialectical relationships between and within the range of socio-cultural and historical processes identified. The result is an array of pathways converging on and emanating from the requirement of control of the menopausal body which is manifest in the three mechanisms of stoicism, 'natural' strategies and HRT. Working backwards from the mechanism or strategy of *stoicism*, normative definitions of the feminine circumscribed by Victorian norms and the legacy of colonialism ensured a social climate of *taboo* surrounding female reproductive functioning. Confronted by a paucity of experience-generated, shared *common sense knowledge*, popular recognition of mid-life problems as 'all in the mind', a belief in hard work as the panacea for mid-life problems, and the risk of social deviance through non-conformity, the women in their seventies and most of those in their sixties accepted an approach of 'getting on with it' as the normal, common sense way to proceed through menopause. In this way the ethic of stoicism was both socially and individually imposed and expected. For those unfortunate to experience difficulties at menopause,

however, the price of social conformity was resentment, regret and sadness over their inability to seek and obtain the help they felt they needed.

Moving down to *HRT*, this mechanism or strategy is underpinned by changes in social and biomedical knowledge and was primarily adopted by the women in their fifties and forties. The pathways to HRT involve the recognition of menopause as a state of ovarian failure, its identification as a disease of hormone deficiency and health risk, and the potential for medicalisation and commodification. Contributing to these developments are social views, involving ageing in a youth culture and individual responsibility for long-term health and well-being, as well as women's changing lifestyles.

*'Natural' strategies* as the third mechanism of control, constitute an extension of stoicism and a reaction to HRT. Most commonly employed by the women in their forties and early fifties, 'natural' strategies usually involve self-motivated and directed techniques without the need for outside or professional assistance. The range of techniques popularly employed included herbal preparations, mind techniques, homeopathic remedies and lifestyle adjustments such as diet and exercise. In contrast with the mechanism of stoicism, however, women opting for 'natural' strategies were able to choose both the mechanism of control and the range of techniques within it. Moreover, if the decision was reached through the pathways of medicalisation and commodification, the choice of 'natural' strategies constituted a rejection of the hegemonic influence of biomedicine. The location of 'natural strategies' between the other two mechanisms was, therefore, indicative of a changing social context involving a diminished taboo and an increased awareness and discussion of menopause. In other words, although those opting for 'natural strategies' were able to exercise choice over the mechanisms employed (a demonstration of agency), they continued to be locked into the required control of the menopausal body if they wished to avoid being perceived as deviant.

It is evident that *control of the menopausal body (the body politic)*, as the central aspect of menopause experience, is itself a manifestation of the complexity of social, cultural and historical processes. Identification of the complex dialectical relationships and multiple pathways between the processes, events and mechanisms of control leads to two conclusions. The first conclusion concerns the inadequacy of the medical model's linear, causal explanations of menopause. Not only does biomedicine disregard the social aspects of menopause but it fails to recognise itself as part of the broader socio-cultural and historical processes which give meaning to menopause. In other words, the biomedical model of menopause presents a narrow, mediated cultural construction of reality. The second conclusion is that women's experience of menopause occurs at the interface of socio-cultural, historical and physiological processes. As a result, the meanings of menopause are fluid and change over time.

#### **IMPLICATIONS FOR HEALTH AND WELL-BEING**

Finally, in light of the impact of the body politic on models of menopause and the three mechanisms of control, the question that arises is what are the implications for the health and well-being of mid-life and older women? The thesis has identified that the majority of women perceive menopause as a normal, natural life-stage and that they reject the deficiency disease model. In other words, the majority of participants did not view menopause as a health risk or illness. Symptoms perceived as being associated with menopause were generally viewed as inconvenient and embarrassing rather than health threatening and even when severe tended to be regarded as temporary aberrations. Consequently, remedial strategies were usually implemented for the purpose of short-term relief rather than long-term health promotion. Viewed in this way it appears that the mechanisms of control rather than menopause itself may hold the most significant implications for the health and well-being of mid-life and older women.

Stoicism was the control mechanism or strategy employed by the older women. For those unfortunate enough to experience severe problems the impact of the strategy on

their well-being was evident in the form of stigma and stress through 'not being able to cope' and their inability to understand, discuss or obtain help for their problems. In common with the remaining strategies there was also the risk that non-related mid-life health problems could be attributed by themselves and others to 'the change' and so develop unchecked and untreated. A classic example was provided by Judy\* who recounted the example of a friend who developed an ovarian cyst that led to her eventual death.

'Natural' strategies frequently involve non-invasive, lifestyle modifications or homeopathic remedies obtained through a trained consultant. However, the use of dietary supplements (particularly those containing phytoestrogens)<sup>4</sup> for the control of symptoms may present a potential health risk. Gross (1998:6) notes that:

many women prefer a 'natural product...it is perceived as much better and they like to do something natural. They do not want to use HRT/pharmaceutical products...[for an event [they see] as a natural life passage'.

The problem is that within New Zealand the classification of dietary supplements as food rather than drugs, means that they are unregulated. As part of an already large and growing 'health' food industry, such products can be freely sold so long as they do not make therapeutic claims (Guy, 1998:4). Gross (1998) and Guy (1998) identify a growing concern among health professionals and women's health groups over the health implications of these products on the grounds of: the lack of long-term studies on the impact of dietary phytoestrogen in humans; the impact of phytoestrogen on animals, particularly the ingestion of red clover by sheep; and concerns that self-induced megadoses may be potentially dangerous.

Finally, control of symptoms with HRT is a response to the view of menopause as a deficiency disease. From this perspective the perception of risk relates to the long-term possibility of osteoporosis and coronary heart disease. Viewed within the context of an ageing female population and the emergent emphasis on personal responsibility, this mechanism allows for the possible denial of state funded treatment to those who

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<sup>4</sup> Phytoestrogens are those found in or derived from plant material.

develop these conditions but failed to take appropriate preventative measures. The difficulty is that the risks and benefits of HRT for both the short- and long-term health and well-being of mid-life women are fraught with controversy and contradiction (see Chapter 3). Consequently, as suggested in Chapter 8, the decision as to whether or not to take HRT presents some women with what appears to be a Hobson's choice; either they take HRT and risk breast cancer or they take nothing and risk crumbling bones and heart disease. In either case, the choice is a demonstration of agency. It must also be acknowledged that women's choices regarding treatment with HRT are made for a variety of reasons, with the most common being the severity of symptoms experienced.

Returning to the original question of the implications for the health and well-being of mid-life and older women, it can be said that there is a need for the education of women and health professionals alike. Such education should emphasise menopause as a normal, natural life-stage and downplay the negative impact of hormonal changes that occur around this time. Indeed, there is an obvious need to alert health professionals to the fact that most of the medical research and information on the management of menopause is based on clinical trials involving the 15 to 20 per cent of women who experience severe symptoms and/or complications at menopause. Although there are currently no national policy guidelines on women's health in New Zealand, the impact of HRT on the health and well-being of mid-life and older women has been raised in a report by The National Advisory Committee on Core Health and Disability Support Services (1993b:7). The first recommendation of this report was that:

All women and relevant health care providers should have access to unbiased, accurate information about menopause and climacteric symptoms, about the effects of hormone replacement therapy (HRT) on these symptoms, and about the acute side-effects of HRT. When considering the long-term use of HRT, postmenopausal women should have access to information about their own long-term risks of osteoporotic fracture, coronary heart disease (CHD) and breast cancer. They should also have access to information about the possible effects of HRT on these outcomes (and on endometrial cancer for women with an intact uterus considering unopposed oestrogen therapy).

## RESEARCH DESIGN AND LIMITATIONS

The study drew on six sources of data - the literature review, menopause educational programmes and material, a content analysis, focus group interviews, in-depth interviews and respondent narratives using a guide. The literature review, an initial series of six focus groups and the content analysis of readily accessible educational programmes and resources (videos, audio-tapes and printed material), all contributed background information with which to examine and understand the women's expectations, perceptions and experiences.

The central research site for the study was the rural town of Feilding and the surrounding Manawatu district. It was in this setting that the six initial focus groups were conducted and in-depth interviewing then took place with a total of twenty-seven participants, some of whom had been involved in the focus groups. An additional twenty-nine respondents were recruited from throughout New Zealand via a notice placed in a national woman's magazine. A total of seventy-two self-selected respondents, who were overwhelmingly of European origin or descent and residents of provincial New Zealand, participated in the study in addition to eight general practitioners (two from Feilding and the remainder from Palmerston North) and three menopause educators from the New Zealand Family Planning Association.

The fieldwork commenced with the six focus groups which served as both an exploratory and a collaborative tool for the study. This approach allowed the Feilding-Manawatu district participants to identify those issues they perceived as the most important for further investigation via in-depth interviews and the narratives provided by the *NZWD* respondents. Two further focus groups, held at later dates, investigated the views and clinical management strategies of a group of Palmerston North general practitioners and the responses of seven women to two educational videos on menopause, respectively. Overall, this qualitative approach was designed to avoid the well known limitations and shortcomings of formal, structured quantitative methodologies, such as those identified by Davis (1986). The study adopted an

inductive methodology and employed the technique of cross-case analysis to synthesise the large amount of data collected.

Although the insights gained from this study make an important and original contribution to the understanding of women's knowledge, expectations, perceptions and experience of menopause in New Zealand, there are nevertheless a number of limitations in the study's scope and design that should be acknowledged. The most obvious limitations concern the choice of the central site for investigation, the process of participant/respondent self-selection and the decision not to make ethnicity a criterion for recruitment. These limitations resulted in a bias toward women of European origin or descent resident in provincial New Zealand whose interest in the research motivated them to become involved. Had the study being designed to recruit participants/respondents who were drawn from a predominantly urban, bicultural (Maori and non-Maori) society with an increasing mix of socio-economic and immigrant cultural groups, a rather different picture of the menopause expectations and experiences of women in contemporary New Zealand may have emerged. A further significant limitation concerns the problem of gaining access to and securing the co-operation of members of the medical profession. Given the recruitment problems experienced (see Chapter 2), it should be acknowledged that the views and clinical practices of those who participated in this study could be somewhat different to those of general practitioners located elsewhere in New Zealand. Similarly, the reliance upon menopause educational audio-tapes to determine the views of specialist consultants, while undoubtedly useful, was nevertheless extremely restrictive with respect to identifying those factors which inform their professional views and clinical practices.

## **FUTURE RESEARCH**

Reflecting my disciplinary perspective as a social anthropologist, the paucity of previous research in New Zealand (see Duncan, 1995; Hamilton, 1990; SROW, 1988), the focus and findings of this thesis and the limitations noted above, several areas for future research come to mind. Four of these areas are briefly outlined below.

### **Ethnicity and Cross-cultural Comparisons**

At a time of an ageing female population and increased life expectancy, questions with regard to future health resources are a growing concern. If available resources are to be most effectively employed, more needs to be known about the current health status of mid-life women in all sections of New Zealand society, especially ethnic minorities. Ethnicity has not been investigated in this thesis, but its salience as a determinant of expectations, perceptions and experience is readily acknowledged<sup>5</sup> and gives rise to the following questions. How do different ethnic groups view menopause and how do their perceptions impact on the long-term health and well-being of women? Can these alternative perceptions and experiences be accommodated within the dominant culture or do they quickly get overtaken, and if so what impact does this have? What fresh perspectives on menopause (and challenges) do ethnic groups offer to the health care system and women in the dominant culture? In the light of such questions there is much to be gained from future research that focuses upon Maori, Pacific Island Polynesian communities and the new Asian immigrant groups in New Zealand society.

### **Medical Treatment of Menopause**

A second area for future research involves the impact of the menopause management and prescribing strategies of general practitioners and other medical professionals.<sup>6</sup> What are the implications for women's health and well-being if practitioner's, such as those identified in Chapter 3, only prescribe from a narrow range of 'tried and true' pharmaceuticals? Are the time/knowledge constraints and relative lack of experience in treating menopause among the majority of general practitioners in this study typical of those elsewhere in New Zealand? Do general practitioners themselves desire better information and professional support, and if so how might this be provided? Should women seeking help with severe symptoms request a referral to a specialist in order to get the treatment regime that best suits their needs? If so, what effect does the training and clinical experience of specialist consultants have upon their menopause management and prescribing strategies? Answers to these questions clearly have an

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<sup>5</sup> See, for example, Beyene (1992), Buck and Gottlieb (1991), George (1988) and Flint (1982b).

<sup>6</sup> See, for example, Barlow et al. (1991), Lock (1982) and Morse et al. (1994).

important bearing upon women's expectations, experience and management of menopause. In order to address these questions there is a need for qualitative investigations of general practitioners and specialist consultants with diverse practice bases in various geographic locations. These studies should involve observation of their consultation practices and prescribing strategies as well as in-depth interviews to identify factors influencing their professional practice strategies, needs and concerns. It is recognised, however, that such research would encounter fundamental ethical issues that would need to be negotiated.

### **Menopause Education**

A third area of future research has already been signalled at various points in this thesis and concerns the need for menopause education of both women and health professionals. In particular, there is the issue of the women's dissatisfaction with both the quality and availability of educational material. Their comments (in Chapters 4 and 5) indicated their desire for neutral (i.e. non-pharmaceutical and non-sensational), easy to read material that embraces both women's experiences and physiological processes of menopause and which emphasises the normal rather than the extreme. The irony is, however, that such material is already freely available within the community and yet the women were either unaware of it or have not taken up the opportunity to utilise it. What are the socio-cultural obstacles to utilisation of educational material and programmes on menopause in New Zealand society? To address this question, future research could profitably examine women's awareness and their assessment of a broad range of educational materials, taking into account the importance of factors such as ethnicity, religious beliefs, educational background and lifestyle.

### **Policy Discourses and Implications**

In the absence of a national policy for women's health in New Zealand, a vacuum exists which allows for debate with the possibility of one or more discourses attaining a dominant position. On the basis of past experience it would have to be said that the odds are in favour of the biomedical discourse maintaining its traditional dominance in the field of health policy. Coupled with the emerging emphasis on a doctrine of

personal responsibility, however, the dominance of the biomedical discourse is likely to have far reaching consequences for women and to give rise to questions such as the following. How is the current policy situation perceived by major stakeholders such as medical professionals, pharmaceutical companies, politicians and women themselves? How will resources be allocated in competition with other health priorities as defined by health providers? What are the implications for women in terms of their attitudes, perceptions, expectations and behaviour towards menopause?

The above represent just a few areas of possible investigation. There is obviously considerable scope even in these areas for interdisciplinary and applied research that would place social anthropologists alongside academics from other disciplines as well as practising health professionals. Such approaches would not only broaden the scope of the research but would make a significant contribution to the establishment of a local knowledge base on menopause and mid-life among New Zealand women.

## APPENDIX 1

### APPLICATION TO MASSEY UNIVERSITY HUMAN RESEARCH ETHICS COMMITTEE

**APPLICANT:** Annette Beasley, Assistant Lecturer, Department of Social Anthropology, Massey University

**PROJECT STATUS:** PhD research project

**FUNDING SOURCES:** Currently personal with departmental support. MURF funding may be sought at a future date if required.

**TITLE OF PROJECT:** A Time of Change: Meanings of Menopause.

**a) Aim:**

To explore the social construction and individual experience of menopause within a New Zealand context.

**b) Objectives:**

- i) to identify and examine the significance of wider social forces on the perception and experience of menopause among a group of New Zealand women.
- ii) to explore the implications of the medical construction of menopause as a hormone deficiency disease on women's perceptions, understanding and experience of this event.
- iii) to identify past and current attitudes, common sense knowledge, myths and expectations towards menopause within the New Zealand context.
- iv) to establish whether women's attitudes towards menopause vary in accordance with age.

**c) Justification:**

To date there has been a marked absence of social research on menopause within New Zealand. Thus little is known of the experience and significance of this event in the lives of local women. At a time of intense debate as to the benefits and risks associated with Hormone Replacement Therapy and the attainment of menopausal status by the first of the 'baby boomers' there is an obvious need for research on the social aspects of, and women's attitudes towards this event.

**d) Recruitment of participants**

Participants will be recruited from six Feilding women's organisations (e.g. Country Women's Institute, Women's Division of Federated Farmers and Plunket Mothers) that meet the research criteria. The executive committee of each organisation will be approached and their assistance requested. If the committees are agreeable they will be asked to distribute information sheets to inform their members of the project and to assist with the recruitment of possible participants. Potential

participants will also be given a consent form authorising the researcher to contact them by telephone. The consent forms will be collected by the executive committee of each organisation and passed on to the researcher. Potential participants will then be contacted to verify their involvement and to arrange a suitable meeting time.

**e) Interviewing procedures/methods**

i) Focus group methodology which may be defined as follows: a discussion amongst a small group of selected people (usually 6-10 individuals) in the presence of a facilitator. The task of the facilitator (who for this project will be the researcher) is to introduce the topic, to guide/focus the discussion via relevant cues and to assist the contribution of all participants in the group. The discussion will be tape recorded and relevant excerpts transcribed and subjected to further analysis.

ii) Individual, face-to-face in-depth interviews.

Selected participants involved in the focus groups will be invited to participate with further in-depth interviewing. The intention is to recruit a total of 30 respondents with a maximum of five women from each of the following six age groups: 30s, 40s, 50s, 60s, 70s and (if possible) 80s.

**f) Informed consent**

Individual consent forms will be obtained:

- i) from the members of organisations granting the researcher permission to contact them
- ii) from each person agreeing to participate in the focus groups
- iii) from those who agree to participate in in-depth face-to-face interviews.

**g) Procedures for handling information and materials produced in the course of research:**

Focus group and face-to-face interviews will be tape recorded and some notes may be taken. Information from both sources will only be accessed by myself and possibly thesis supervisors. Only those excerpts of the tapes considered relevant will be transcribed by the researcher and direct quotes may be used to illustrate points in the discussion. Information collected will be filed and securely stored during the investigation. All tapes and notes will be destroyed once no longer required for research purposes.

**ETHICAL CONCERNS:**

**a) Access to participants:**

Access to participants will be accomplished via their membership of voluntary social organisations. The researcher is firmly committed to the process of voluntary participation and this will be attained via the procedures outlined above (see 'Recruitment of participants').

**b) Confidentiality:**

Confidentiality will be assured for all participants involved in individual in-depth interviews. That said, names/identities will be altered in any written material to protect individual identity but participants will be given the option of being named and identified in any publication if they so desire.

The issue of confidentiality of matters raised during the course of focus group interviews among those present will be negotiated with each group prior to commencement and noted on the consent form.

Tapes and interview notes will be filed and kept secure by the researcher throughout the investigation.

**c) Potential harm to participants.**

Harm to participants will be avoided through maintaining confidentiality where requested and through conformity to the Ethical Guidelines for Research required by the New Zealand Association of Social Anthropologists of which the researcher is a member.

**d) Participants' right to decline:**

The recruitment process outlined above should eliminate any pressure to become involved in the project. Each consent form will also emphasise the right of the participant to withdraw at any time without explanation or recrimination.

**e) Arrangement for participants to receive information:**

The researcher will undertake to return to each organisation to present an overview of the research findings if they so wish. Both organisations and those individuals who wish to will be advised of any publications associated with the project.

**f) Use of information:**

The consent form will make clear that any information received will be used for a thesis and academic publications.

**g) Conflict of interests:**

None are foreseen.

**LEGAL ISSUES:****a) Copyright:**

Copyright of the thesis and published papers resulting from this research project will be held by Annette Beasley.

**b) Ownership of data or material used:**

This will be retained by the researcher and destroyed when no longer required for research purposes.



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Private Bag 11222  
Palmerston North  
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Telephone +64-6-350 4492  
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## **Example of Information Sheet Handed Out to Interested Participants**

### **A TIME OF CHANGE: MEANINGS OF MENOPAUSE INFORMATION SHEET**

This research is being undertaken by Annette Beasley and involves a study on menopause and women's attitudes, understanding and experience of this event. This research is for the purposes of a PhD thesis and will be supervised by Drs. Lovelock and Tennant. Out contact addresses/telephone numbers are as listed below:

**Researcher:** Annette Beasley  
Department of Social Anthropology  
Massey University  
Telephone: 356 9099 Extn 4911

**Supervisors:** Dr. Kirsten Lovelock  
Department of Social Anthropology  
Massey University  
Telephone: 356 9099 Extn 4913

Dr. Margaret Tennant  
Department of History  
Massey University  
Telephone: 356 9099 Extn 4236

My field of interest is Social Anthropology and in particular medical anthropology with a focus on women's health. I have been involved in a previous study of four first time breastfeeding mothers in the Manawatu area and am currently part of a further investigation of factors influencing breastfeeding success and failure.

#### **BACKGROUND AND NATURE OF THE STUDY**

Until very recently menopause was a subject that was not really talked about in polite company and many women going through this event have had little knowledge about what is happening to them.

Many of you will be aware of Sandra Coney's book, *The Menopause Industry* (1991) and the arguments she makes about the advantages and disadvantages of Hormone Replacement Therapy. Sandra's book seems to have stimulated a lot of comment on menopause in women's magazines, on the radio and among women themselves. Despite this, no one really knows very much about the attitudes and experience of New Zealand women to this event. The aim of this project therefore is to find out about women's ideas, beliefs and attitudes towards menopause and to see what the experience was actually like for some of those who have been through this bodily change.

I would like to invite you to be part of this research project. Your involvement would be as a member of a small group of between six and ten women from your organisation meeting to discuss a number of issues associated with menopause. This meeting or Focus Group interview would be arranged to take place at a venue and time convenient to each member of the group and would last for approximately two hours. After this interview is completed some members of the group will be invited to participate in a further individual interview to take place at a later, mutually agreed venue and date. The women involved in these second interviews will be selected on the basis of age, as I wish to see if attitudes towards menopause vary according to age. All interviews and focus group meetings will be tape recorded.

The material gained from this study will be used for my PhD thesis and subsequent academic publications. My field of interest is Social Anthropology and in particular medical anthropology with a focus on women's health. I have been involved in a previous study of four first-time breastfeeding mothers in the Manawatu area and am currently part of a further investigation of factors influencing breastfeeding success and failure.

Participation in this study is voluntary and you may withdraw at any time without fear of recrimination or the need to state a reason for doing so. Confidentiality of material is guaranteed and recorded tapes and notes will not be accessed by anyone but my self and my academic supervisors.

You will be notified of any publications resulting from the study should you wish.

Please feel free to discuss your possible involvement with family and friends. If you want any further information or would like to discuss what your participation in this project would involve I can be contacted through Massey University, telephone 356 9099 ext 4911. I would be very happy to talk with you.

Annette Beasley



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New Zealand  
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**Example of Consent Form sent to Social Organisations**

**A TIME OF CHANGE: MEANINGS OF MENOPAUSE**

**CONSENT TO BE CONTACTED**

1. I agree to be contacted about possible involvement in the above study. I understand that this does not imply consent to participate in the study.
  
2. I understand that I will be contacted by Annette Beasley asking if I am willing to participate in a Focus Group interview. I can ask further questions about the study at this time and understand that I will not be contacted again if I decline to participate.
  
3. I understand that if I agree to participate in the study I can withdraw at any time without explanation or recrimination. If I have any questions about the study I can contact Annette Beasley on the telephone number listed in the information sheet.

Name.....

Address.....  
.....

Telephone number.....

Signed.....

Date / /

**PLEASE RETURN TO A COMMITTEE MEMBER OF YOUR ORGANISATION**



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**Example of Consent Form for Focus Group Interviews**

**A TIME OF CHANGE: MEANINGS OF MENOPAUSE**

**FOCUS GROUP INTERVIEW**

**CONSENT FORM**

1. I agree to be a member of a Focus Group interview for the above research project. I understand that I can withdraw at any time without explanation or recrimination.

2. I understand that confidentiality of information obtained by Annette Beasley is guaranteed and that any information I provide will be used for research purposes and academic publications only.

*Strike out which does not apply*

I agree to my name appearing in any published material

I do not agree to my name appearing on any published material and would like to be referred to as.....

3. I understand that audio tapes and notes of the Focus Group interview will be held by Annette Beasley and destroyed when the research is completed.

4. As a member of the ..... Focus Group I undertake to maintain confidentiality on personal matters discussed by other members of the group during the interview.

5. I wish to be advised of any material published from this study.

Yes/No (*Please circle option*)

If yes please provide address in space below

.....  
.....

Signed.....

Date / /



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**Example of Consent Form for In-depth Interview**

**A TIME OF CHANGE: MEANINGS OF MENOPAUSE**

**CONSENT FORM FOR PERSONAL IN-DEPTH INTERVIEW**

1) I agree to participate in a personal interview conducted at a time and in a place nominated by myself. I understand that I have the right to withdraw at any time without explanation or recrimination.

2) I understand that confidentiality of information is guaranteed and in a situation where the discussion touches on matters I consider extremely personal or sensitive I may request that such material not be used in any form of publication.

3) *Strike out which does not apply*  
I agree to my name appearing in any published material

I do not agree to my name appearing on any published material and would like to be referred to as .....

4) I understand that notes and audio tapes of my interview will be held by Annette Beasley and destroyed when the research is completed.

5) I wish to be advised of any material published from this study.

Yes/No (*Please circle option*)  
If yes please provide address in space below

.....  
.....

Signed.....

Dated / /



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Palmerston North  
New Zealand  
Telephone +64-6-350 4492  
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## APPENDIX 2

### Example of letter to Feilding social organisations

The Secretary

Dear

I am writing to your organisation to request assistance with the recruitment of women for a research project that I wish to carry out in the Feilding area. The aim of the project is to explore among a diverse age group of women (aged thirties upwards) attitudes towards menopause and, where appropriate, experience of menopause.

My intention is to establish a series of discussion or focus groups. Each group will comprise a maximum of ten women recruited from a particular Feilding social organisation. The aim of each focus group will be to establish what knowledge and information women themselves possess on menopause and which issues they consider are in most need of investigation.

In order to undertake such a project I need a mechanism through which to make contact with club group members. I therefore request that your committee bring the research project to the attention of your members through distribution of the enclosed information sheets. I would also appreciate it if you could provide me with a list of names and telephone numbers of women who would be willing to be contacted about **possible** involvement in the project.

This project has been approved by the Massey University Human Ethics Committee. Conditions of ethics approval include a guarantee to respect confidentiality and the right of all participants to withdraw at any time from the project without explanation or recrimination. The point I wish to stress here is that any names collected and submitted to myself will indicate interest in possible participation only and will not obligate anyone to become a member of a focus group discussion.

As indicated on the Information Sheet I can be contacted through the Department of Social Anthropology, Massey University, telephone 3669 099 extn 4911 if you have any further questions. If required I am prepared to meet with you and your committee in Feilding to discuss this request further.

I look forward to your response,

Yours sincerely,

Annette Beasley

## APPENDIX 3

### Example of Questionnaire Completed at the Beginning of the In-depth Interviews

NAME.....

1. In what year were you born?
  
2. Where were you born?  
Country  
City/town
  
3. *If born overseas*  
How many years have you lived in New Zealand?
  
4. How long have you lived in the Feilding district?
  
5. Which of the following groups do you feel you belong to:
  - i. Pakeha New Zealander
  - ii. New Zealander
  - iii. Maori
  - iv. European
  - v. Other
  
6. What is your highest educational qualification?
  
7. What is your usual occupation?
  
8. What is your present occupation?
  
9. What is your marital status?

10. *If married/living with partner*

What is your husband/partner's usual occupation?

11. What is your husband/partner's usual occupation?

12. What is your husband/partner's current occupation?

13. Do you have any children?

Yes/no

*If yes*

How many?

14. Who are your closest living female relatives?



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## APPENDIX 4

### **Example of Letter Sent to the Women Responding to the *New Zealand Woman's Day* 'Helpline' Notice.**

January 1996

Dear 'Woman's Day' reader,

Thank you for responding to the 'Helpline' advertisement regarding my research project on women's experience of menopause. I am finding this a very exciting and rewarding project and have to date been interviewing women within the Manawatu area. The project commenced with a series of focus groups, where up to six women discussed those aspects of menopause they considered important. Following on from these groups I have so far individually interviewed about twenty women, in addition to a couple of husbands and two general practitioners. I hope to finish this stage of the project about the end of February. Your contribution will allow comparison of the ideas and experiences of women from throughout New Zealand with those of the Manawatu women.

You will see from the Information Sheet that this is a doctoral research project and so, initially at least, the information obtained will be presented in academic form. It is, however, also my intention to produce a book for more general readership and I hope to have this available within the next five years.

You would probably like to know little about myself. I am 50 years of age and have a family of five children ranging from 26 to 18 and including a wonderful grandson of fifteen months, the child of my eldest son and wife. Currently I am a lecturer at Massey University, a position I have held for the last four years having returned to the workforce after 21 years of being a wife and mother. I have come to academic life late having studied part-time while the children were growing up and have (as indicated in the Information Sheet) already done a study on breastfeeding mothers which will be published through the Department sometime next month. Obviously, given my age, the topic of menopause is of particular personal interest and I am finding it a fascinating subject to investigate and am full of admiration for the wonderful women I have come in contact with so far. I feel very strongly that this is an area long neglected by

- do you feel menopause is a subject that women talk about among themselves
- what do you know about the physical process of menopause
- what information would you like to be made available on menopause and how do you think this could best be done
- do you think there is a need for support groups for menopausal women
- what are your views on Hormone Replacement Therapy
- what sort of attitudes towards menopausal women have you encountered among your family, friends, workmates and others

*I would also appreciate the following as background information:*

- the age when you had your first period and whether or not you knew about periods before your first bleed
- any problems associated with menstruation including Premenstrual Tension (PMT)
- if you have ever been on the contraceptive pill and if so, for how long
- your age and highest level of educational qualification
- your occupation
- your husband/partner's occupation
- number of children (if any)
- who are your closest living female relatives

Any information on the above areas or other comments you may wish to make will be most appreciated and contribute to the scope of this study. Thank you for taking the time to enquire about this project.

## Example of the Information Sheet Sent to New Zealand Woman's Day Respondents

### BACKGROUND AND NATURE OF THE STUDY

Until very recently menopause was a subject that was not really talked about in polite company and many women going through this event have had little knowledge about what is happening to them.

Many of you will be aware of Sandra Coney's book *The Menopause Industry* (1993) and the arguments she makes about the advantages and disadvantages of Hormone Replacement Therapy. Sandra's book seems to have stimulated a lot of comment on menopause in women's magazines, on the radio and among women themselves. Despite this, no one really knows very much about the attitudes and experience of New Zealand women to this event. The aim of this project, therefore, is to find out about women's ideas, beliefs and attitudes towards menopause and to see what the experience was actually like for some of those who have been through this bodily change.

If you decide to write to me I would particularly like to know about the following:

*If you have been through menopause:*

- at what age did menopause start
- how long did your menopause appear to go on for
- did you experience any symptoms and if so how did you know they were associated with going through menopause
- did you need any medical treatment to help you through menopause
- If yes, please describe what, how long the treatment continued and whether or not it helped you
- did you seek information on menopause and if so where or from whom
- how do you feel about your experience of menopause

*If you have not yet reached menopause:*

- at what age do you expect to go through menopause
- how will you know you have reached menopause
- do you expect to experience any symptoms as a result of menopause. If so could you describe these
- are you looking forward to reaching menopause, please say why you feel this way
- where would you go to find more information about menopause

*Everybody:*

- have you ever discussed menopause with your mother

researchers and hope that the current project will give a voice to the thoughts and experiences of many New Zealand women.

I enclose an Information Sheet outlining the nature of the research project and the type of information sought. The questions on the Information Sheet are intended as a guide only and may not all be relevant to your experience, so please do not feel obliged to comment on all points mentioned. I wish you to feel free to tell me whatever you feel is important to you regardless of whether or not it is mentioned in the Information Sheet.

Also enclosed is a Consent Form. Would you please fill this in and return it with your comments. This project has been approved by the Massey University Human Ethics Research Committee on condition that all participants give written consent. You will notice that the Consent Form asks whether you wish to be known in any written material by your own name and if not you are given the opportunity to choose the name you wish to be identified by. Please indicate your preference and note that first names only will be included in any published material.

Finally thank you for your interest and time, and please do not hesitate to contact me should you have any further enquiries.

Best wishes

Annette Beasley



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Private Bag 11222  
Palmerston North  
New Zealand  
Telephone +64-6-350 4492  
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## APPENDIX 5

### Example of Letter Sent to Feilding General Practitioners

Dear Dr.

Since mid-September I have been conducting a series of Focus Group interviews with women from the Feilding area on the social construction and individual experience of menopause. The purpose of these interviews has been to identify central themes for further investigation through in-depth interviewing.

Among the themes to emerge from the Focus Groups was one concerning the importance of contact with General Practitioners. As part of the second stage of the project I would, therefore, appreciate the opportunity to conduct a taped interview with yourself. The focus of the interview would be on the practitioner view of menopause, treatment of difficulties, type of information available to women through practitioners, and an overview of the types of enquiries, knowledge and expectations held by women who seek consultation.

I understand the need for patient confidentiality and do not seek to compromise such a commitment. I realise that you are only free to offer a personal view on matters discussed. Confidentiality of information is guaranteed and the project has the approval of the Massey University Human Research Ethics Committee.

If you agree to be interviewed I anticipate the interview duration to be approximately one hour, the session to occur at a time and venue suitable to yourself.

I enclose a copy of the Information Sheet that has been distributed among the women involved in Focus Group interviews and am happy to be contacted to discuss the project. I can be contacted on telephone number 350 4911 (Massey University) or 357 8509 (home). Unless I hear sooner I will contact you in approximately a week's time regarding your decision. Meanwhile your time in reading this letter is appreciated.

Yours sincerely,

Annette Beasley  
Lecturer in Social Anthropology

**APPENDIX 6****Example of the Questionnaire on the Video and Audio-tape Educational Programmes****QUESTIONNAIRE  
EDUCATIONAL PROGRAMMES ON MENOPAUSE**

**1 a** Have you ever seen/heard this programme before?

Yes/No

*(please circle correct option)*

**if yes**

**b.** Where did you see/hear it

**c.** When did you see/hear it

**d.** How did you come to know about the programme

**2** Do you feel better informed as a result of seeing/listening to the programme

Yes/No

**b** Why do you say that

**3a** .What aspects of menopause (if any) did the programme help you to understand better?

**b** In what way

**4a** Was there anything about menopause you wanted to know that the programme did not cover?

Yes/No

**If yes,**

What other information would you have liked have to seen included on the programme

**5a** What aspect(s) of the programme impressed you most

**b** Why do you say that

**6a** Was there anything you did not like about the programme?

Yes/No

**if yes,**

**b** Why do you say that?

**7a** Would you recommend the programme to other women seeking information on menopause

Yes/No

**b** Why do you say that

**1** On a scale of 1 - 5, with 1 being the least emphasis and 5 being the most emphasis how would you rate the emphasis placed by the programme on the following aspects of menopause

**a** The physical changes that occur in a woman's body at menopause

1      2      3      4      5

**b** Vaginal dryness, hot flushes and night sweats as common menopausal symptoms

1      2      3      4      5

**c** Tiredness, sleep disruption, mood swings, depression as common menopausal symptoms

1      2      3      4      5

**d** Osteoporosis in post menopausal women

1      2      3      4      5

**e Cardiovascular disease in post menopausal women**

1      2      3      4      5

**f The role of diet and exercise in the prevention of osteoporosis**

1      2      3      4      5

**g The use of vitamins and alternative strategies to reduce the impact of menopausal symptoms**

1      2      3      4      5

**h Women's views on their experience at menopause**

1      2      3      4      5

**i Menopause as a normal stage of a woman's life cycle**

1      2      3      4      5

**j Benefits associated with the use of hormone replacement therapy**

1      2      3      4      5

**k Menopause as a hormone deficiency disease**

1      2      3      4      5

**l Risks associated with the use of hormone replacement therapy**

1      2      3      4      5

**m The benefit of hormone replacement therapy for all women**

1      2      3      4      5

**n The need for all women to see their doctor during the menopause**

1      2      3      4      5

**o Women's own (ie non medical) strategies for coping with menopause and its symptoms**

1      2      3      4      5

**2 On a scale of 1 to 5 with one being the least helpful and 5 being the most helpful, how would you rate the programme**

1      2      3      4      5

**3 On a scale of 1 to 5 with 1 being the least positive and 5 being the most positive, how positive was the view of menopause presented by the programme**

1      2      3      4      5

**4 Are there any further comments you would like to make about the programme**

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