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Menopause, Sex and HRT: An Analysis of the Social Meaning

of Heterosexual and Lesbian Women's Experiences

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Menopause, Sex and HRT: An Analysis of the Social Meaning of Heterosexual and Lesbian Women's Experiences

by

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Chapter 1

Introduction

Introduction to Study

How do women experience menopause? At a biological level, menopause occurs because of hormonal changes and the fulfillment of ovarian function. Once ovaries finish releasing their eggs, women stop menstruating. The transition to the final menses may include physical and emotional changes including hot flashes, erratic periods, vaginal dryness and mood swings. But biological events are experienced within cultural contexts. In particular, culture influences how women experience and view the physical and emotional changes associated with ovarian fulfillment. This dissertation analyzes in-depth interviews with 30 heterosexual and lesbian women about their menopausal and midlife sexuality experiences. I examine the social meaning of their experiences to understand how their accounts are influenced by cultural expectations about menopause. In addition, I examine the importance of gender, sexual orientation, race and class for women's experiences with menopause.

In this chapter, I describe in detail the goals of this dissertation. I first explain the biological changes that occur during menopause and how they may be relevant for women's sexual functioning. Next, I discuss how menopause is socially constructed by providing examples of different ways that menopause is experienced cross-culturally. This discussion is followed by an historical overview of the social

construction of menopause in the United States. I then review the sociological theory I use to guide my analysis. Next I describe the contributions of my research. I conclude by explaining why I focus on sexual orientation in my analysis and I summarize the goals of the dissertation.

What Is Menopause and How Does It Affect Women?

On average, women stop menstruating by 52, and by 54, ninety percent of women are postmenopausal (Perry and O'Hanlan, 1992). However, just as some girls start menstruating early, some women stop menstruating early, in their 30's. This early menopause is known as "premature menopause" (Love and Lindsay, 1997:10). Menopause occurs because women's ovaries eventually run out of eggs and this process affects their bodies' production of estrogen and progesterone. After menopause, women's bodies continue to produce estrogen, but at lower levels. Women's ovaries and adrenal glands secrete a hormone called androstenedione, which becomes converted into estrogen in fat cells. Consequently, the more fat a woman has, the more estrogen she produces. In fact, obese women often do not experience hot flashes or vaginal dryness because of the greater amount of estrogen produced in their fat cells (Landau et. al., 1994; Perry and O'Hanlan, 1992).

Before the final menses, a transition period called perimenopause occurs, which can last from three to ten years. During perimenopause, estrogen levels soar and plummet as a woman's body transitions to its non-menstruating state. Some

women sail through perimenopause unaware that anything is happening with their bodies. Other women experience physical, emotional, sexual and/or menstrual changes before their last menses that vary from minor to irritating to severe (Mansfield and Voda, 1997). The research on menopausal symptoms shows that most women report having at least one common perimenopausal symptom, but a minority of women suffer from severe or debilitating symptoms (Avis and McKinlay, 1991; Mansfield and Voda, 1997).

Perimenopause involves biological changes that may be relevant to sexual functioning. For example, hormonal changes cause the vaginal lining, the vaginal epithelium, to thin over time. Premenopausal women may have forty to fifty layers of epithelial cells while postmenopausal women may have four to five layers (Landau et al., 1994). Some women experience vaginal dryness and sensitivity to touch (Landau et al., 1994). The vagina also becomes shorter and narrower at menopause and its elasticity and the fatty tissue in the labia are reduced. While these changes, which can be compounded by vaginal dryness, may bother some women during penetration (Landau et al., 1994), the vagina remains large enough for penetration (Perry and O'Hanlan, 1992). The covering of the clitoris may also thin and pull back leaving the clitoris more exposed and more sensitive to touch (Perry and O'Hanlan, 1992). In addition, some women may experience less sexual desire and reduced orgasm intensity because of decreased levels of testosterone and estrogen (Barbach, 1993a).

Approximately twenty-five percent of women experience vaginal dryness five years after the last menstrual period, but vaginal dryness may become worse with time (Coney, 1992; Landau et al., 1994). However, women have several options to help maintain vaginal lubrication during sex with penetration. They can use water-soluble jelly and hormone replacement therapy (HRT), and avoid substances that can dry and irritate the vagina such as douches, perfumed soap and toilet paper as well as medications, such as antihistamines, that can cause dryness (Perry and O'Hanlan, 1992). Maintaining regular orgasmic sexual activity either with a partner or through masturbation appears to help reduce problems with vaginal dryness. Orgasm helps exercise the vagina because of the muscle contractions and increased blood flow, which occur before and during orgasm. Some researchers believe that sexual activity may stimulate estrogen production in the adrenal glands, which helps maintain vaginal lubrication (Perry and O'Hanlan, 1992). Also, taking testosterone can help restore desire and orgasm intensity (Barbach, 1993a; Perry and O'Hanlan, 1992).

The technical meaning of menopause refers to a specific point in time, a woman's last menses. As noted above, the transitional period is referred to as perimenopause and the time after the last menses is called postmenopause. However, the common use of menopause refers to both the transitional period and the time after the last period. In this dissertation, I use menopause to refer to the menopausal transition or perimenopause, and postmenopause to refer to the time after a woman's last menses.

Cross-Cultural Views of Menopause

Sociologists understand that biology, psychology and culture affect women's experiences with menopause in interrelated ways. Menopause is clearly a biological process because hormonal changes within women's bodies result in the cessation of menses. This process can result in physical and emotional changes, such as erratic periods, hot flashes, vaginal dryness and mood swings. Yet how women *view* these changes and their postmenopausal bodies is socially constructed. Not only do women's views on menopause vary cross-culturally, but also their experiences of physical changes and what those changes mean to them vary.

For example, women in a Newfoundland fishing village welcome hot flashes as purifiers because they believe that hot flashes are caused by "too much or bad blood" (Martin, 1987:166). In addition, in many non-industrialized countries, women gain freedom and status when they become postmenopausal. After menopause, Thai women can speak about topics that younger men and women would not discuss together. Kapauku Papuan women and Chinese women are released from the authority of their husbands. And Cree women cannot exercise shamanistic power until after menopause because the concepts of healing and menstruation are antithetical (Griffen, 1982).

The reporting of physical changes varies across cultures as well. Canadian women report fewer problems with physiological changes such as hot flashes than

American women (Lock, 1993). And the Japanese do not have a word for hot flash; the most common complaint of Japanese women is stiff shoulders (Lock, 1993). Therefore, women's experiences of menopausal changes as well as their perceptions of those changes vary across cultures. The meaning of menopausal changes for women seem to be linked to the status of aging women within each society (Ginsburg and Rapp, 1991; Lee and Sasser-Coen, 1994). Consequently, if women gain power and value within a society, they may view menopause and aging more positively than women who live in a society that devalues aging.

Social Construction of Menopause in the United States

Historically, in the United States, the dominant cultural story about menopause characterized it as "The Change." This construction defines women by their reproductive organs and views their primary roles as reproducers. Women experience many changes throughout their lives; to characterize menopause as the most important change essentializes women's bodies and purpose in society (Lee and Sasser-Coen, 1996; Martin, 1987). Not all women have children, for example. Furthermore, "old wives' tales" construct menopause as a period of physical decline and emotional upheaval. Many women in this study recounted childhood stories they heard about menopausal women becoming irritable, depressed and insane, and losing interest in sex. These cultural stories depict middle-aged women as victims of their

hormones and reflect aging women's devalued status within our society (Lorber, 1997).

Historically, the medical establishment ignored menopause (Ferguson and Parry, 1998). Arguably, medicine's so-called discovery of HRT and subsequent definition of menopause as a deficiency disease in the 1960s helped stimulate a public discourse about menopause that never existed before. Therefore, when HRT first became available, women who sought medical care could discuss menopause with their doctors, although the perspectives they received were very limited (McCrea, 1983). By comparing menopause to a deficiency disease like diabetes, medicine conceptualized menopause as a medical problem and women's bodily processes as pathological and in need of medical assistance (Love and Lindsay, 1997).

In the early 1990s, Gail Sheehy's book, *The Silent Passage* (1991), became widely available and very popular. Sheehy openly wrote about the physical changes caused by menopause as well as sexuality, aging, and HRT. Her book was arguably the first of its kind because it gave women an accessible and detailed way to learn more about menopause. Since the publication of her book, many more popular books have become available as well as an increasing number of articles in women's magazines (Gannon and Stevens, 1998).

Today, the public discourse on menopause is much more open and accessible. Women can read books, magazines and newspaper articles, talk to their family, friends and doctors, and attend seminars on menopause and HRT. Menopause is no

longer a "Silent Passage." Unfortunately, an overwhelming number of media articles about menopause characterize it as negative or a disease and focus on HRT as the primary way to manage menopausal "symptoms" (Gannon and Stevens, 1998). With few exceptions, articles do not discuss issues of aging, lifestyle, exercise or diet (Gannon and Stevens, 1998). Therefore, while the public discourse about menopause is more open, the dominant cultural story continues to construct it negatively, primarily as a problematic health condition.

Within each findings chapter, I review the relevant bodies of research on menopause, including with respect to women's expectations and experiences (Chapter 3), menopause and sexual functioning (Chapter 4), and health care utilization and HRT use (Chapter 6). Much of this research is based on surveys that document women's rates of physical and emotional change. Such research reifies the cultural construction of menopause as a biological problem and the idea that female hormones cause certain types of behavior in women. Although many feminist health researchers and activists have critiqued the medicalization of menopause and resisted the medical establishment's promotion of HRT to "treat" the "symptoms" of menopause (Coney, 1991; Love and Lindsay, 1997; McCrea, 1983; McPherson, 1990; Parry and Ferguson, 1998; Worcester and Whatley, 2000), little of this writing and research offers women's narratives about menopause, midlife and HRT. This research thus overlooks the social context of women's lives and the social

significance of their experiences. Also, much of this research is based on limited samples of white, heterosexual, middle-class women.

Much of this previous research does not document how women actually perceive and experience menopause. Do they experience it as a problematic health time, as a time of physical and sexual decline? Or do they view it as a time of freedom from periods and unwanted pregnancies? What do they say about their sexual functioning? Do they consult doctors for medication to help them through the menopause transition? How do they feel about their doctors and HRT? In this dissertation, I document women's experiences with menopause to offer their perspectives on the meaning of menopause during this social and historical period.

Theoretical Background

The major goal of this dissertation is to understand the social significance of heterosexual and lesbian women's experiences with menopause and midlife sexuality. I argue that reframing menopause from an individual experience of a biological event to a *social* experience highlights ways in which various social arrangements and social factors contribute to how women view menopause and their midlife sexual functioning. Although I do not argue that gender is the only social arrangement that shapes women's experiences, I believe that the social construction of menopause is based on cultural expectations about gender, femininity and heterosexuality. I am guided in my analysis by three theoretical frameworks. First, the work of Judith

Lorber (1993) and Robert Connell (1995) emphasizes the cultural construction of gender. Second, West and Zimmerman (1987) offer an analysis of "doing gender," which highlights how gender is created through interactions. Third, Karin Martin's framework (1996), which builds on Jessica Benjamin's ideas (1986), provides a guide for analyzing female sexual agency.

Feminist theorists conceptualize gender as a social construction in many different ways. Judith Lorber and Robert Connell, among others, conceptualize gender as a socially constructed identity and a process, according to Lorber (1993), and "a way in which social practice is ordered," according to Connell (1995:71). In other words, gender is socially constructed in individuals' lives through a social process of interactions in a society that is culturally and institutionally organized according to gendered assumptions (Lorber, 1993; Connell, 1995).

Most feminist sociologists maintain that the characteristics associated with gender, masculinity and femininity, are culturally-determined and malleable. They can change over time depending on the values of groups who are in power (Connell, 1987; Segal, 1993). A constant feature of masculinity, however, is that it is a construct in opposition to femininity and is culturally valued more (Benjamin, 1988; Connell, 1987; Segal, 1993). Consequently, femininity is constructed as inferior to masculinity and is valued less.

Connell conceptualizes the dominant form of masculinity within any historical period as "hegemonic masculinity," and he calls the dominant form of femininity

"emphasized femininity" (1987). For example, in the United States, the media narrowly focus on certain characteristics they associate with masculinity and femininity, such as being white, young, heterosexual, and conventionally attractive, and perpetuate images of this ideal in magazine and television advertising as well as television shows and movies. These ideal images of masculinity and femininity are emblematic of the current forms of hegemonic masculinity and emphasized femininity.

Hegemony entails dominance, power and resistance. Gramsci (1971) conceptualizes hegemony as (cited in Martin, 1987:23):

> …the permeation throughout civil society…of an entire system of values, attitudes, beliefs, morality, etc. that is in one way or another supportive of the established order, and the class interests that dominate it…to the extent that this prevailing consciousness is internalized by the broad masses, it becomes part of "common sense."

In Connell's conceptualization, hegemonic masculinity and emphasized femininity are cultural ideals that are unattainable (see also Segal, 1993). No man or woman can embody this ideal, although many support it (Connell, 1987; Williams, 1995) because they benefit from these dominant beliefs and attitudes. This theory should not be perceived as a "social conspiracy," however. People within a society are socialized and participate in a system that, as the above quote describes, they may experience as "common sense," or how things "should" be. For example, men "should" be the primary breadwinners within marriages or women "should" compromise or sacrifice

their careers to raise children. These social expectations, in turn, support the interests of the most powerful groups in society.

The concept of hegemony also includes resistance (Connell, 1995). According to Connell, alternative forms of masculinity and femininity exist, but these alternative forms are not given the same status and power as the dominant constructs. For example, gay masculinity may embrace qualities and activities that contest characteristics associated with hegemonic masculinity. That contestation does not confer social authority, however, so gay men are typically placed at the bottom of the gender hierarchy among men (Connell, 1995). But the important point for my analysis is that alternative forms of masculinities and femininities can and do exist. I attend to these alternative forms of femininity in my dissertation.

Currently, heterosexuality is an important characteristic associated with hegemonic masculinity and emphasized femininity. Heterosexuality implies more than male-female desire and specific sexual practices. Rather, it is a "social process that creates, organizes, expresses and directs desire" (MacKinnon, 1987:49) and a social institution that shapes social life (Rich, 1980; Wilkinson and Kitzinger, 1993). In other words, assumptions about heterosexuality are embedded in institutions and cultural practices. For example, heterosexuality is legitimized through the institutions of marriage and the family, religion, and the law. Assumptions about heterosexuality are reflected in socialization practices such as children's literature, classroom lessons, and playground games (Rich, 1980; Thorne, 1986).

Individuals' assumptions about love and sex are shaped by social expectations about gender and heterosexuality, which emphasize male desire and women as objects of male desire (Connell, 1995; Martin, 1996; Rich, 1980). Dominant cultural ideas about gender normalize heterosexuality as natural rather than a social construction and an individual choice (Butler, 1990; Lorber, 1993; Rich, 1980; Wilkinson and Kitzinger, 1983). These expectations become internalized and reproduced through interactions, which confirm dominant cultural ideas about gender and heterosexuality as normal (Lorber, 1993), or how things "should be."

Past research shows that just as people "do gender" (West and Zimmerman, 1987), people also "do heterosexuality" through interactions (Giuffre and Williams, 1994). Because gender is a process, however, individuals do not reproduce gender in a "rote fashion" (Lorber, 1993:51), yet through everyday interactions they either conform to or resist cultural expectations and norms (Lorber, 1993). Analyzing the various ways women exercise their agency, including sexual agency (Davis, 1993; Deveaux, 1994; Martin, 1996), is important for understanding how "differences among women—age, race, culture, sexual orientation, and class—translate into myriad variations in response to ideals of femininity and their attendant practices" (Deveaux, 1994: 227).

Attending to female sexual agency is particularly important in my analysis of women's accounts on sexual functioning after menopause, which is discussed in Chapter Four. I draw on Martin's description of female sexual agency as the ability

to recognize and act on sexual desire as well as women's ability to act in their bodies instead of feeling acted on (1996). According to Benjamin (1986), a person's agency, or the feeling that she can act in the world, is connected to her body and sexuality. Sexual subjectivity, or the feeling of acting in her body and on her desire, is an important component of agency and therefore is important for a positive sense of self (Martin, 1996). My study provides examples of many midlife women acting on their sexual desire and in their bodies. In some cases, women suggest that they did not develop female sexual agency until their adulthood.

In Chapters Five and Six, I examine the role of medicine in advising women to take a drug, HRT, for the rest of their lives. I argue that the medical promotion of HRT stems from the relationship between the social organization of medicine in a capitalist society and the social organization of gender. I describe these ideas more fully in Chapter Five. In Chapter Six, I analyze women's accounts of their interactions with their doctors and decisions about HRT to illustrate the ways that the social organization of medicine and gender create a set of social forces that frames HRT as a good choice for women's long-term health. I analyze these accounts theoretically to understand how the social organization of medicine and gender medicalize menopause and discount women's embodied interpretations.

In summary, the goal of my theoretical analysis is to articulate the dialectic between dominant cultural expectations about menopause, gender and heterosexuality and how different women respond, accommodate, and resist these expectations. This

analysis will help illuminate how women are both active agents in social life and limited by "structured forms of constraint" (Fisher and Davis, 1993: 9) or the cultural and structural constraints of femininity and heterosexuality.

Contributions of This Research

The dissertation contributes to three different areas of study. The major contribution is to research within sociology of health and illness generally, and gender and health research specifically. The narratives from my subjects provide texture for understanding the social meaning of their menopausal and midlife sexuality experiences. The methodology of this research contributes to creating a discourse of menopause as a normative event based on women's lived experiences. In other words, this research helps reframe the menopausal experience based on women's lived experiences rather than imposing a construction of menopause as a problematic biological event.

Unlike much of the past research on menopause, which defines menopause as the absence or presence of a list of "symptoms," this research highlights the ways that social factors such as midlife, gender, sexual orientation, race, and class, influence and shape the meanings of women's menopausal and midlife sexual experiences. Understanding the social context in which women experience menopause is important because the current dominant cultural ideas about menopause construct it as a health problem. This approach individualizes and pathologizes women's menopausal

experiences. When menopause is defined as a health condition, then the logical goal for each woman is to find a "cure" for the menopausal change that she finds difficult or unpleasant. The current medical approach, for women who seek medical care, is to prescribe HRT as the solution for women's uncomfortable or difficult menopausal "symptoms."

By illustrating the importance of social factors, this research highlights how some women's difficult menopausal experiences are shaped by problematic social arrangements. For example, while many women in this study describe menopause as inconsequential overall, they describe hot flashes in public settings as embarrassing, hard and unpleasant. I argue that part of the reason women find hot flashes difficult is because we live in a society that devalues aging and aging women. The hot flash in and of itself does not fully explain *why* so many women experience it as difficult in public settings. Understanding the social significance of women's menopausal experiences illustrates how aging women are perceived and devalued within our society.

This research contributes to feminist theory of gender and femininity as well. I analyze women's accounts to understand how the link between menopause and dominant ideas about gender and femininity may influence the meaning of their menopausal experiences. In other words, I analyze how expectations about menopause are based on dominant ideas about gender and femininity and the ways those ideas shape women's experiences with menopausal changes such as hot flashes,

mood swings, heavy bleeding and vaginal dryness. I also examine ways that women respond, accommodate and resist cultural expectations about menopause, gender and femininity.

The third and final area of contribution is to feminist theory of heterosexuality and sexual agency. I analyze how women discuss physiological changes during menopause that are relevant to sexual functioning to understand how dominant ideas about menopause and heterosexuality influence their perception of those changes. I also provide empirical evidence about ways that women recognize and act on their sexual desire to document how women exercise sexual agency.

Role of Sexual Orientation

Theoretically, as discussed, I analyze women's accounts to understand how social expectations shape women's menopausal experiences. At the same time, I attend to women's use of agency. Certainly not all women respond in the same ways to cultural expectations about menopause and sexuality, for example. I compare women's experiences by race and class but primarily focus on sexual orientation. I base my definition of lesbian on how women identify their sexual orientation now. Many lesbian-identified women have heterosexual pasts. I use the terms heterosexual and lesbian for analytical purposes, not to imply that sexuality is dichotomous and fixed. In this study, many lesbian women's experiences refute the notion of a binary system of sexuality.

I focus on sexual orientation not because I believe that sexuality is more important than race or class for women's menopausal and mid-life sexual experiences. Sexual orientation, race and class intersect in important ways. However, an examination of sexual orientation expands a sociological understanding of how dominant cultural ideas about menopause are linked to assumptions about gender and heterosexuality.

For example, when I examined women's accounts on menopausal changes and mid-life sexuality, I noted that more heterosexual women with vaginal dryness describe it as problematic for their sexual pleasure than lesbians with vaginal dryness. My analysis of their accounts suggests that this difference by sexual orientation is due to different definitions of sex. Heterosexual women define sex as intercourse while lesbians have more flexible definitions of sex. Consequently, many heterosexual women follow the dominant cultural script of heterosexual sex by engaging in intercourse when their husbands initiate it, instead of taking the lead in other sexual activities that would allow more time for lubrication. In contrast, most of the lesbians in this study say they talk to their partners about vaginal dryness, experiment with different ways to have sex, and communicate during sex. These accounts suggest that the meaning of menopausal changes for women's sexual relationships differs by sexual orientation. This analysis illustrates how women at the margins, who do not conform to societal norms, may provide a unique perspective to examine and understand the social organization of gender (Harding, 1991; Collins, 1991).

Goals of the Dissertation

In summary, this study provides empirical evidence on women's expectations about and experiences with menopause, sex, health care and HRT. The research questions that this dissertation investigates and compares by sexual orientation are: How do women describe their menopausal expectations and experiences? What do women say about their sexual functioning after menopause? Do they distinguish between sex and intimacy? Do women seek medical care for menopausal changes? What do their doctors say? How do women feel about their medical care? How do they decide whether to take HRT?

This study contributes to menopause research based on women's descriptions and the meanings of their experiences without a preconceived framework of menopause as a negative event (Mansfield and Voda, 1995; MacPherson, 1990). Because past research on menopause, sexuality, doctors and HRT is largely based on white, middle-class, heterosexual samples, the findings will broaden a sociological understanding of the various ways menopause is experienced by a diverse group of women in this historical and social period.

Organization of Chapters

In Chapter Two, I describe the methodology of the study and the sample. Chapters Three, Four and Six comprise the empirical findings of this study. Chapter

Five reviews medical studies on the benefits and risks of HRT and critiques the medical promotion of HRT. The dissertation concludes with Chapter Seven, in which I summarize the major empirical findings of this study and the theoretical contributions. Finally, I describe the social policy implications of this study.

Chapter 2

Methodology

In this chapter I turn from the theoretical justification for my research to design and research issues. In the first section, I explain why qualitative methods are best suited to address the questions of my dissertation, using examples from the study, and also acknowledge the limitations of these methods. The second section explores study design issues. The third and final section contains a discussion of the social aspects of field research and my role as a feminist researcher in this process. Qualitative researchers' view social reality as dynamic, changing, and complex (Orum, Feagin, and Sjoberg, 1991) and because of these epistemological assumptions, they focus their research questions on social processes and social meanings. Given these assumptions about social reality, I cannot ignore the social aspects of the research process itself and my role as a researcher. Therefore, the last section of this chapter contains my reflections on the social aspects of field research including my role as a researcher and the ethical considerations I weighed while conducting research.

Qualitative Methods: Rationale, Strengths and Weaknesses

Rationale and Strengths

Qualitative methodology has many benefits. First, this method allows researchers to contextualize respondents' experiences socially and historically so that researchers can compare continuity and change over time in human and social patterns (Orum, Feagin and Sjoberg, 1991). For example, by documenting women's experiences with menopause and midlife sexuality, future researchers can compare their findings with mine as well as analyze how cultural and social processes have remained the same or changed over time. As the population continues to age and the public discourse about menopause increases, perhaps cultural attitudes and values about aging will become more positive. In turn, these positive values may positively affect women's expectations and experiences with menopause.

Another benefit of qualitative methods is observing social actors and actions in natural settings, which allows the researcher to "make claims grounded in the claims of those who make them" (Orum, Feagin and Sjoberg, 1991). This benefit contains two components. First, I interviewed most of the respondents in their homes, where I could converse with and observe them in surroundings familiar and comfortable for them. For example, the respondents suggested places in their homes to sit and talk, usually around a table or on a couch in a family room. We often first discussed family pictures, their yards, how long they have lived in their homes and other topics familiar and comfortable to the respondents. Through these small interactions based on topics about their lives, the respondents relaxed as we developed a rapport.

By conducting the interviews in these women's homes, I believe the respondents opened up in ways that could have been more difficult if we met in a neutral setting, such as a restaurant, or in a professional setting, such as their workplace or my office. For example, many of the respondents either teared up or openly cried throughout the interviews. Many also told me personal stories about past sexual abuse and current problems in their relationships. Several respondents confided that they never told anyone else some of the stories they shared with me. I believe that because I met women in their homes, they felt relaxed and comfortable to express themselves in ways that would have been difficult in other settings.

Second, because my research is based on open-ended in-depth interviews, I learned about women's experiences with menopause, their relationships, midlife and past sexual experiences and traumas, health crises, and doctors and hormone replacement therapy according to their descriptions and perspectives. In-depth interviewing allows researchers to explore with their respondents what their experiences *mean* to them, so the claims I make about women's experiences and the meanings of those experiences are based on their perspectives.

The interpretations of women's experiences are entirely my own, however, but because my claims are supported with quotes from the interviews, this method best allows me to present and critique women's experiences as they understand them. For example, many women reflect on the process of aging and their relationships, and these reflections illustrate some ways midlife women respond to cultural ideas about

menopause and femininity. Qualitative methods allow me to document their responses to and interpretations of cultural norms (Williams, 1991). In contrast, a random survey relies on sets of questions prepared in advance of the interview and reports actions or beliefs without contextualizing the respondents' answers (Orum et al., 1991).

Finally, a third benefit of qualitative methods is "that it lends itself to theoretical innovation and generalization" (Orum et al., 1991). Theoretical generalization allows researchers to examine earlier concepts and interpretations in innovative ways or suggest new interpretations and concepts (Yin, 1984, cited in Orum et al., 1991). Because qualitative methods produce rich data, the researcher can use this data to interpret social processes and social meanings to inform or expand existing theory. In my study, I interpret and critique heterosexual and lesbian women's extensive personal accounts of their menopausal experiences to inform gender theory on issues such as female sexual subjectivity, hegemonic masculinity and emphasized femininity and compulsory heterosexuality. Throughout my dissertation I confirm and extend aspects of these theories.

Researchers who use qualitative methods focus on the "richness and the subtle nuances of the social world" (Orum, Feagin, and Sjoberg, 1991: 23), which requires flexibility for making judgments about the social world as well as the ability to negotiate meanings in discourse (Mishler, 1986). In contrast, quantitative researchers tend to assume a fixed and uniform social world which can be examined by asking a

random sample of individuals a series of questions in the exact same order. The results of these answers are analyzed statistically to generate inferences from the smaller randomly selected sample to the population as a whole. This method isolates the individual from his or her social context because it assumes that universal truths about human nature and social reality exist independent of individuals' particular social worlds (Sjoberg et al., 1991)

Qualitative researchers also seek to generalize but these generalizations reflect different ontological and epistemological assumptions about human nature and the social world. Instead of generalizing beliefs, actions and feelings of isolated individuals to a larger population across time and place, qualitative researchers generalize patterns of behavior of individuals who share similar social settings in particular historical periods: "We may conclude that the nature of the phenomenon that one studies is the true gauge of the population to which one seeks to generalize. It is not merely a question of how many units but rather what kind of unit one is studying" (Orum, Feagin and Sjoberg, 1991:15). For example, the experiences of the 30 postmenopausal women in my study, who were primarily recruited from small towns during the year 2000, are probably similar to the experiences of other Northeastern and Midwestern small town postmenopausal women across the country in this particular social and historical time. Similarly, the experiences of some of the lesbians I recruited from a large urban area will probably resonate with the experiences of other postmenopausal lesbians in urban areas.

The experiences of the women I interviewed most likely differ from the experiences of women more than100 years ago, at the turn of the century, when HRT was not yet developed. The life expectancy at birth for white women in 1900 was 51.08, for women of color it was 35.04 (U.S. National Center for Health Statistics, 1999 and 2000) and, therefore, not as many women lived long enough to go through menopause compared to today. However, white women who lived to 50 could expect to live almost 22 more years, and women of color could expect to live almost 19 more years (U.S. National Center for Health Statistics, 1999 and 2000). Perhaps those women viewed menopause positively, as a sign that their childrearing days ended and that they were among the fortunate ones to live past life expectancy. Or perhaps they viewed it as a marker of aging. In contrast, today white women's life expectancy at birth is 80, for women of color it is 74.8 (U.S. National Center for Health Statistics, 1999 and 2000). Therefore, most women can expect to live 25 to 30 years after menopause.

In this dissertation, I analyze women's menopausal experiences to understand how dominant cultural ideas about menopause, femininity and heterosexuality influence those experiences. Therefore, the generalizations I make about social processes are unique to this social and historical period which values youth and heterosexuality and narrowly equates female beauty with the young, white, thin female body (Davis, 1995), despite the aging of the population.

In summary, the benefits of qualitative research include contextualizing women's experiences by historical, social and cultural period as well as the particular social contexts of respondents' lives. Qualitative methods allow me to observe and interact with my respondents in natural social settings, which helped developed our rapport. This method allows flexible discourse and negotiation of meanings so I can understand their perspectives as much as possible. Finally, this method allows me to contribute to and expand on sociological theories of gender and heterosexuality.

Weaknesses

All methods have limitations and weaknesses. Qualitative methods are no exception. Two weaknesses that are relevant for my study are generalizations about frequency and issues of reliability (Williams, 1991). Qualitative methods cannot answer how often an attitude, behavior, belief, expectation or experience happens and generalize the percentage of that occurrence to a larger population. For example, even though most women in my study experienced vaginal dryness, I cannot take the percentage of the women in my study and generalize it to all postmenopausal women in the United States. My sample is too small and is not randomly selected. Instead, a researcher could use a survey distributed to a larger, randomly selected sample to make inferences about how common certain physical changes occur in women after menopause.

Whether research is reliable or consistent is an important measure of a project's soundness in sociology. Quantitative methods achieve reliability by relying

on the same set of questions, which are theoretically administered in the same way to each respondent. In-depth interviewing does not follow this stimulus-response structure and, therefore, is not viewed as reliable as quantitative methods. Qualitative interviews follow a semi-structured interview guide but allow for deviation from that guide when the respondent's answers call for different follow-up questions; therefore, different respondents may be asked different questions. Not all sociologists agree that reliability should be accorded such importance in the discipline, however. According to Williams, "reliability has been overrated in sociology" (1991:240). She argues that validity or reflecting accurately what happens in the social world is more important and qualitative methods achieve validity better than quantitative methods (1991:240).

In any event, I believe that researchers choose the method that best allows them to answer their research questions. My study is not focused on how often various experiences happen to women but rather the meaning of women's menopausal and midlife sexuality experiences and how women respond to cultural norms of femininity and heterosexuality. Qualitative methods are best suited to answer the questions of the dissertation.

Research Design and Sample Description

Study Design: Interviews, Question Guide and Analysis

This study is primarily based on 30 in-depth interviews with postmenopausal lesbian and heterosexual women who have experienced menopause with their ovaries intact or naturally. Surgically-induced menopause, which is caused by the removal of both ovaries, results in a sudden withdrawal of estrogen. This type of menopause causes more extreme vasomotor and emotional changes than for women who experience natural menopause (Landau et al., 1994), and the age at which it can occur ranges from early 20s to mid-50s. Therefore, I exclude women with surgically-induced menopause because I am focusing on women who experienced menopause naturally and to understand how they feel about themselves after this transition.

When I met with a respondent, I first gave her a cover letter describing my study and informed her that she is a volunteer and that she could terminate the interview at any time for any reason (see Appendix A: Cover Letter). Then I asked some demographic questions about her age, race, household income, marital or partner status, number of children and occupation. Before I began the in-depth interview, I first generally described the types of questions I planned to ask. I tape recorded all of the interviews, which generally lasted from one and a half to two and a half hours each; however, two interviews lasted more than three hours. I also took notes during the interviews to remember key words for follow-up questions, to document non-verbal communication and to note whispered responses, which I knew the recorder would not pick up. Finally, I kept a field notes journal in which I reflected on each interview and the research process as it unfolded.

I followed the protocol of the Human Subjects Review Board at the University of Texas at Austin. I ensured anonymity to the respondents and protected their identity by using pseudonyms throughout the dissertation and changed any identifying characteristics such as the names of husbands or partners, workplaces and/or doctors.

As previously stated, the purpose of this dissertation is to examine women's experiences with menopause, midlife sexuality, doctors, and hormone replacement therapy, as well as to understand how women feel about these experiences. I examine women's accounts not only to understand women's experiences from their perspectives but also to analyze how dominant cultural ideas about menopause, femininity and heterosexuality influence these experiences. Therefore, I developed an open-ended questionnaire based on my theoretical framework that included six topics: 1.) expectations and experiences with menopause in general, 2.) body image and beauty practices, 3.) intimate relationships, 4.) menopausal experiences at work, 5.) doctors and hormone replacement therapy, and 6.) general questions on future goals and aging issues (see Appendix B for Question Guide).

I deviated from the question guide when a women's unique experience led to other issues. In particular, I departed from the interview guide when women discussed past sexual traumas, and when lesbians discussed past heterosexual relationships, marriages and their first lesbian relationship. For example, when I talked to women about sexuality and intimacy issues, several women first discussed

past sexual traumas such as incest or rape. I did not expect so many women to share these personal past crises with me. When they did, first, I always empathized with them and acknowledged that talking about these incidents must be painful. Depending on the woman and the way these sensitive topics arose, I would offer to turn off the tape to let her get Kleenex or a glass of water. These breaks often helped me as well to collect my thoughts and think about how to proceed in the interview. Often times I then would follow-up with questions to try and understand how these past incidents affected how they currently feel about sexual intimacy.

Sometimes women's descriptions of past sexual experiences led me to include a new question for subsequent respondents. For example, Jane, a 61-year-old Caucasian married for 40 years, explained that, until recently, she could never relax to have an orgasm during sex with her husband. When we discussed why she has trouble relaxing, she recalled the first time she had an orgasm, with a high school boyfriend, and said she felt very frightened because she did not know what was happening to her body. In college, however, she learned about the benefits of masturbation and has masturbated "on and off" since then. After my interview with Jane, I started asking women about first orgasms and masturbation to explore other women's experiences with these issues. Therefore, my discussion on women and masturbation is not based on the full sample.

I followed the question guide for my interviews (see Appendix B), but not all of the women were asked exactly the same follow-up questions. In addition to these

questions, I asked women how they felt about my questions and if they wanted to add anything else. In particular, after the sexuality section I often said, "Now before we move on, I want to make sure you are okay because I realize that those questions were very personal and sensitive. Are you feeling okay?" During this portion of the interview, many women then told me that they had never talked to anyone about their sexual relationships in detail. Many also said they felt fine and found our discussion helpful, particularly if they currently have problems in their relationships.

Each interview was transcribed either by a transcriber, who I hired to assist with this project, or by me. If I did not transcribe an interview, I listened to the tape and checked the transcripts to fill in areas the transcriber did not fully understand. I have read and reread all of the transcripts a number of times to analyze the data and categorize themes according to the theoretical framework I used in designing the study. Sometimes I found themes inductively, as they emerged from the data, which I also categorized and marked. I primarily compared women's experiences by sexual orientation but also separated the interviews by race and class to analyze how themes compared according to these categories as well.

Study Design: Advantages and Weaknesses

I believe that the best way to find out how women experienced menopause and feel about those experiences and themselves as midlife women is to ask them. An advantage of in-depth interviews is that they allow for an open dialogue and a negotiation of meanings. When a respondent and I did not understand each other, we

simply asked each other for clarification. This dialogue is tape-recorded and transcribed so I can review and understand this clarification process.

A second strength of in-depth interviewing is that it documents inconsistencies and conflict in people's accounts, which allow researchers to analyze and critique how people respond to and interpret social norms and social processes. For example, Brenda, a 58-year-old lesbian partnered for eight years, first says that her sexual interest and activity decreased because of aging; she says:

> Ann and I don't have sexual relations and haven't for several years. And it's like it's a mutual thing and it's agreeable and it's not an issue….It's just as nice without it, oh well, that's what I hear. Older people, that's what happens. So it's just that we sort of accept it as not a problem. I mean it has never come up in our couples counseling at all. So, it's not something that we feel a need to fix or to do anything about.

As the interview progresses, she discusses her relationship problems in more detail, reveals that she masturbates sometimes when Ann is not in the house, and also describes her attraction to another woman. In one follow-up question, I ask about her expectation of not having sex because of aging and if she thinks she will not have sex for the rest of her life; she says: "I think that would be a possibility. I think I would be more surprised if, especially if I started a new relationship. Then I would think that (sex) would be part of it."

Brenda's account about sexual desire and activity contains a few inconsistencies. Even though she attributes her lack of interest in sex to aging, her discussion of her relationship problems reveals that she is not feeling close to her partner right now. And she says, "I need to feel intimate and then I have sex." The

fact that she masturbates indicates that her sexual interest has not entirely waned with age. Finally, her expectation that, in a new relationship, she would have sex, again, highlights the role of relationship quality rather than expectations about aging.

Brenda's conflicted account about her expectations about sex and aging and the role of relationship quality alerted me to consider and analyze the meaning of her inconsistencies. First, she explains that her lack of sex with her current partner is "not a problem" because that can just happen as people age. From a sociological perspective, she is responding to and interpreting cultural and social expectations about aging and sex. Her subsequent conflicted account about her sexual desire and activity, however, suggests that a social factor, her relationship quality, plays a more significant role in her current level of sexual activity than her expectations about aging. Because in-depth interviewing allows for open dialogue and story telling, I can analyze women's descriptions for the types of conflict and inconsistencies I found in Brenda's account.

A final methodological advantage of this study is framing midlife sexuality and intimacy questions around issues of the menopausal transition. I found that the first part of the interview engaged and relaxed women as they shared their experiences about hot flashes, mood swings, and erratic periods. When we turned to relationships, we continued our discussion of menopausal changes and used it as a launching pad into other sexuality issues. These discussions gave me insight into a variety of midlife sexuality issues, many of which are not related to menopausal

changes, including partners' health problems, relationship troubles and past sexual experiences. Because women brought up other sexuality issues, I could more fully understand the context of women's midlife sexual relationships as well as the meaning of menopausal changes for their relationships.

I believe that I would have found greater difficulties recruiting volunteers or would have recruited a disproportionate number of women who are comfortable talking about sex for this study if it was based solely on midlife sexuality issues. Many of the women I interviewed did not strike me as feeling relaxed as they talked about their sexual relationships. In my observations, I found that many women initially stopped maintaining eye contact and resorted to short sentence answers to my questions about their relationships, particularly for those women in unhappy relationships and for some of the women with traumatic sexual histories. As the interviews progressed, however, many of these women opened up and answered with more detail to my follow-up questions or returned to sexuality issues later in the interview.

For example, Beth, a 54-year-old Caucasian married for 31 years, alluded to problems in her marriage, which she did not feel comfortable detailing, but did say that she and her husband were seeing a sex counselor. I sensed that she wanted to tell me more, but I told her I respected her privacy and we would simply move on to another section of the interview. She abruptly returned to sexuality issues at the end of the interview, however, when I asked what type of advice she would give a

younger woman about menopause. First, she asked me whether I have done any research on pornography on the Internet. Then she commented that she thinks the availability and variety of pornography on the Internet is disgusting. In a very offhand way, she mentioned that she recently found out her husband views pornography on the Internet. We then discussed the problems this discovery has caused for her and how she feels simultaneously confused by his interest in this material and inadequate about her aging appearance. Beth also told me that she has not talked to anyone about her relationship issues because she does not want her family or friends to know that her husband enjoys pornography.

Beth is a very soft-spoken person. In fact, I found transcribing her interview time-consuming because of my difficulty understanding her on the tape. I think Beth probably would not have volunteered for a midlife sexuality study. But because my study is primarily about women's menopausal experiences, we first developed a rapport on a topic in which she was interested in discussing. I believe that our rapport allowed us to discuss sexuality issues, a topic with which she was not very comfortable.

In summary, this study design allowed me to negotiate meaning and analyze conflicted and inconsistent statements. Framing midlife sexuality issues around menopause gave me greater insight into the range of midlife sexuality issues women experience after menopause. The study design may have also allowed me to learn

about a greater variety of women's experiences than a study based solely on midlife sexuality.

Study Design Weaknesses

This study design contains a few possible weaknesses. First, I cannot compare women's experiences by type of menopause because I excluded women with surgically-induced menopause. Therefore, my observations about this sample represent a certain type of menopausal experience and do not give insight into how women experience menopause surgically.

Second, the interviews occurred after women experienced menopause so they are reconstructing their experiences about the menopausal transitional in light of their present lives and perspectives. Although most of the respondents are in their 50s, some are in their early 60s and the oldest is 71 (although she is also a member of the Nurses Health Study, an ongoing study on a variety of health issues over time. This respondent has regularly documented her experiences with menopause, HRT, and her health). For the older women in the study, recalling their menopausal experiences and how they felt about them may have been even more difficult.

However, none of the women told me they could not remember anything about their menopausal experiences. For example, all of the women who had hot flashes easily recalled specific examples. Many of the women may feel more positive about menopause as time passes than they did as they experienced it, but because my

study focuses on women's feelings about midlife and aging after menopause, this possible more positive reconstruction is not problematic for my findings.

Third, I found recruiting lesbians difficult. My sample has 11 lesbians who are relatively more educated and earn a higher household income than the sample overall (see section on *Sample Description*). Therefore, my sub-sample of lesbian women is not as diverse socio-economically as my sub-sample of heterosexual women.

Sample Characteristics and Selecting the Sample

I interviewed 30 postmenopausal lesbian and heterosexual women who experienced menopause naturally or with their ovaries intact. Overall, 24 of the 30 women interviewed are employed full or part time and work in a variety of occupations. The ages of the respondents range from 46 to 71; the median age is 56. Nineteen women are heterosexual and eleven are lesbians. The sample includes 21 Caucasian women and nine women of color including five African-American women, one Hispanic-American, one Japanese-American, one Native American and one multiracial woman, who is Caucasian, African-American and Native American. Fourteen of the women's households earn $50,000 and above and 16 women's households earn less than $50,000. For highest level of education, one woman earned a Ph.D., six women earned Master's degrees, nine women earned Bachelor's degrees, and 14 women earned high school degrees (see Table 1: Sample Characteristics).

The lesbian sub-sample is more racially diverse, has higher incomes and is relatively more educated. Of the eleven lesbians interviewed, seven are Caucasian and four are women of color, including two African-Americans, one Hispanic-American, and one Native American. For income, seven households earn $50,000 and above, and four earn less than $50,000. For education, one lesbian woman earned a Ph.D., one earned a Master's degree, four earned Bachelor's degrees and five earned high school degrees.

In contrast, the heterosexual sub-sample consists of 14 Caucasian women and five women of color, including three African-Americans, one Japanese American and one multiracial woman. Seven women's households earn $50,000 and above and 12 women's households earn less than $50,000. In terms of education, five earned Master's degrees, five earned Bachelor's degrees, and nine earned high school degrees. (See Tables 2 and 3: Sample Characteristics by Sexual Orientation).

Selecting the Sample: Considerations and Setbacks

I conducted two pre-test interviews, which were then included as part of the overall sample; they are Janet and Margaret. I found Margaret, a 52-year-old Caucasian married for 36 years, through a friend. Margaret is my friend's relative. I interviewed Margaret twice because after listening to the tape and reflecting about the interview, I added more questions. We met for a total of almost four hours. I thoroughly enjoyed talking to Margaret and she was open and very honest with me. About three weeks after the interview, however, I ran into Margaret and her husband

at the park with their grandchildren. All three of us interacted awkwardly; I suspect we all recognized that the last time I talked to Margaret, she shared very personal and intimate details with me about her relationship. After this encounter, I decided to recruit women whom I most likely would never see in other social settings.

I recruited women in a variety of different ways, including posting fliers at doctors' offices and at the YWCA's free mammogram program, requesting volunteers from members of the American Association of University Women and the YWCA, advertising through the Mautner Project's (a lesbian support group) newsletter; and asking friends and colleagues. After each interview, I asked women for references and through purposive snowballing, I found seven of the 30 women interviewed.

Most of the interviews took place in women's homes; two took place at my home and one took place at a respondent's office. I interviewed most women in central Pennsylvania; five women (all lesbians) were interviewed in the Washington D.C. metropolitan area. Sometimes I drove long distances to meet with women in Pennsylvania or D.C., over 200 miles roundtrip. In these cases, the whole interview process lasted over six hours.

As stated earlier, I found locating lesbians very difficult, although some of the lesbians I interviewed tried to find volunteers for me. For example, the first lesbian I interviewed, Janet, sent an e-mail to ten of her friends in the central Pennsylvania area, asking them to participate. No-one volunteered. When I talked to Janet about

it, she laughed and said that some of her friends told her they felt insulted that she assumed they were old enough to have gone through menopause, an interesting sociological response in itself. These women imply that becoming postmenopausal is negative. Others rhetorically asked her, "Now why would I want to talk about menopause with a stranger?"

I worked hard to find lesbians for this study. I called several support groups and organizations in D.C. and Harrisburg and asked for volunteers; most of these calls did not result in volunteers. Finally, the advertisement in the Mautner Newsletter, a support group for lesbians who have family or friends with cancer, produced four volunteers. One of these women referred me to a friend. I found four of the other six lesbians through various contacts and two of these women gave me names of their friends.

The other setback I encountered concerned rescheduling many of the interviews for various reasons, which I am sure is inevitable with this method. Women are volunteering their time to talk to me and most of them work and lead busy lives. Two women, in particular, cancelled the scheduled interview several times and I wondered when I should just give up on them. I felt reluctant to stop trying, however, because in my first phone conversation with them, they both described interesting personal accounts. For example, Ellen, a 53-year-old Caucasian married for 35 years, responded to one of my fliers in a doctor's office. When she called me, she told me that she had breast cancer, took HRT for awhile which she

recently stopped, and said she is unhappy with the medical advice she has received and is confused about what to do. I am glad I persisted in finding a time to talk with her, though, because her account is very interesting not only about doctors and HRT, but also about relationship issues.

Similarly, Pat, a 64-year-old multiracial divorced heterosexual, contacted me in response to an ad at the YWCA's free mammogram site. Pat has many health problems and leads a stressful life, in part, due to her low, part-time income between $10,000-15,000. She cancelled because of her health and other family crises, but always encouraged me to call her back in a couple of weeks. I persisted and we met and she told me many intense and alarming stories about living a wealthy life with her first husband who died in a car accident and was cheating on her, losing two children, losing her job as a nurse, and watching her health and economic status decline with age.

The difficulties and setbacks I found recruiting a diverse sample by sexual orientation, race, and class, made the interviewing process longer than I had originally planned. I conducted the bulk of my interviews from December 1999 through August 2000.

Social Aspects of Interviewing: My Role as a Researcher and Ethical Issues

Field research is a scientific enterprise and a social enterprise (Anspach, 1993). Working with human subjects involves social interactions, which lead to a

variety of situations in which I decided which questions to follow-up and which to leave unasked. These decisions ultimately affected the type of data I did and did not collect. My role as a researcher, literally who I am may have affected the type of data I did or did not collect. In this section, I explicitly reflect on interviewing and my role in the research process and discuss some ways these social aspects may have influenced my data. I conclude this section by discussing some ethical issues that arose during some interviews and how I resolved these issues.

My Role as a Researcher

I am a 37-year-old Caucasian premenopausal woman who has been married for seven years and has three young daughters. I first started research on the social aspects of menopause when I took Debra Umberson's class, Gender and Health, in the spring of 1994. I wrote my thesis critiquing the medicalization of menopause, which I submitted for my Master's in the fall of 1996. From that research, I developed my research questions for this dissertation.

My interest in the social aspects of menopause has spanned eight years to date, including some breaks to have children and move across the country to Carlisle, PA. When I interviewed women about menopause and doctors for my thesis research, I argued in a methodology paper for Christine William's qualitative methods course that the fact I am premenopausal is a strength for my research. I explained to women that I have not experienced menopause, I have only heard and read about other women's stories. So, when I asked questions about what certain

experiences are like for women and asked them to provide detailed descriptions and examples, they would respond with the understanding that I do not know firsthand what they are talking about, such as what a hot flash feels like. Consequently, I believe that my status as a premenopausal woman gave my respondents a sense of expertise about menopause during the interviews, which provided me with rich detailed data about women's various menopausal experiences.

The fact that I am heterosexual may have initially affected which questions on sex I did and did not follow-up with lesbian respondents, particularly in the beginning of the research process. For example, in my first interview with Janet, a Caucasian lesbian partnered for 19 years, she first told me that she was "avidly heterosexual" most of her life. She could not find an "emotionally sustaining" relationship with a man, so she turned to women. She describes herself as a "situational lesbian rather than a constitutional lesbian." Then she described an amazing and loving relationship with her partner. When I asked her to describe her sexual relationship, she laughed and said: "Nonexistent!" She has been taking Prozac for 11 years and said that she thinks it affects her libido, but she does not miss having sex. She enjoys their affection, cuddling, hugging and kissing.

I can still remember my reaction to her answer that she does not have sex and does not miss it; I was completely surprised. The description of her relationship up to that point was so glowing, I expected her to describe an active sex life. In part because Janet was my first interview and is a very outspoken person with a strong

personality, and in part because I am heterosexual, I remember feeling very uncertain about how to follow-up to her response that she does not have sex and does not miss it. I asked her: "Do you talk about this (not having sex) as anything that concerns either one of you?" She said: "What? That we don't have sex? No! (laughter)."

I felt self-conscious during this part of the interview because I did not know what to do. I thought about the literature that suggests lesbians have sex less frequently than heterosexuals (Blumstein and Schwartz, 1983). I also felt that she did not want to talk about her sexual relationship anymore. So, I was uncertain whether I was imposing my assumptions about sex and happy relationships to her relationship and confused about whether I should move on or not. I continued by asking her whether she feels intimate with her partner and she said yes, and then described cuddling in bed and stroking her partner's arm until she falls asleep.

Looking over this interview many months later, I wish I had asked her more questions about her relationship with her partner and her first experiences with lesbian sex. I do not know whether Janet is simply not interested in lesbian sex but decided to commit to a female relationship for emotional reasons or whether she enjoyed lesbian sex at one time and has become used to a decreased libido because of Prozac. I could have asked her if she would be willing to try a different anti-depressant that does not affect her libido. Perhaps her response would have provided insight into her feelings about lesbian sex or sex in general. At the time, however, I

felt uneasy and uncertain whether I was imposing heterosexual assumptions on to her relationship, which, in part, prevented me from probing with additional questions.

As I became more comfortable with the interview questions on sex, I followed-up with more detailed questions and felt more relaxed doing so. For example, in my seventh interview, with Sarah, a 58-year-old Caucasian married for 35 years, she told me that her husband "can't salute anymore" because of prostrate problems. Then she described an unsatisfying sexual relationship, which I discuss in detail in Chapter Four. After this description, I wanted to ask her about masturbation, a topic I had started asking most women; I said: "What about—this is very personal, so you don't have to tell me." Sarah: "Well, I think the rest has been personal! (laughs)." When Sarah responded, I did not feel self-conscious that I had asked personal questions, instead I asked her whether she was feeling okay about our discussion so far. She reassured me that she was fine and then I continued by asking her about masturbation and also told her that some women do this; she said: "I can do that."

My comfort level with the interview guide affected the types of probes I did and did not ask as the research process unfolded. Also, when I sensed that women were very uncomfortable talking to me about their sexual relationships, I felt conflicted about my concern for my respondents' feelings and wanting to follow through with my research questions. Most of the time I tried to continue sensitively with the interview, reminding the respondent that she did not have to answer my

questions. Most women did answer my questions because they told me that their anonymity helped them feel comfortable.

In summary, the scientific enterprise of gathering data from the field is intertwined with the researcher's social structural location and the social relationship between researcher and respondent. These social aspects shape the nature of the data that the researcher collects or does not collect. I do not think that these aspects are unique to in-depth interviewing, but are most likely part of any social scientific research that involves social interaction, regardless of the research design.

Ethical Issues

Interacting with human subjects raises ethical issues, not only about protecting their identity, but also about which information to share and which to withhold. For example, in my project, respondents discussed health concerns about taking or not taking HRT and sometimes asked my opinion about what they should do. In one case, a respondent, Mary, a 57-year-old Caucasian married for 38 years, discussed extreme vaginal dryness which results in bleeding during intercourse. She had breast cancer and is not a candidate for HRT. However, during the interview, I recalled reading that breast cancer survivors can use an estrogen vaginal cream sparingly, which could help with the dryness. During this interview, I had to decide whether to share this information or not.

As a feminist researcher, I opted for sharing information with my respondents because I decided that, while withholding information may not necessarily harm my respondents, it may fail to help them (Anspach, 1993). I was careful to share my information by first emphasizing that I am not a doctor and am not trained in medicine; my knowledge about HRT comes from reading scientific journals and popular books on menopause. I gave women names of books that they could consult themselves. Generally, I did not advise women to take or not to take HRT because I cannot make this decision for them, and it is not my role to do so.

However, in some cases, I told women about new developments in estrogen medication that I believed may help them with vaginal dryness. For example, I told Mary about using an estrogen cream sparingly, but clearly emphasized that she should discuss using this cream with her doctor and oncologist. Also, Daphne, a 60-year-old Caucasian lesbian partnered for 15 years, takes HRT for vaginal dryness, among other things, but is not sure how long she will continue taking it. I told her about a new vaginal ring which is inserted like a diaphragm and releases estrogen locally, not systemically. Again, I emphasized that she should consult her doctor to determine when and if she should discontinue HRT, but also pointed out that she has other options to alleviate her vaginal dryness.

Each researcher weighs whether to assume a passive role and withhold information or to share information. In my case, I generally felt that my inclination to share information was the right ethical decision, particularly since I gave women my

sources. In Mary's case, I felt particularly good about my decision after I received the following note from her, several months after our interview:

> Dear Julie,
>
> I want to thank you for your recommendation about vaginal cream. I asked my gynecologist and he agree that in low doses & used infrequently, it was considered safe for breast cancer survivors. After using only four doses I could tell a big difference. If not for our discussion of the subject I would never have asked him about it.
>
> I hope everything is well with you & your family. Continued good luck on your research project. You can be assured that you have benefited at least one person.
>
> Thanks again,
>
> Mary XXXX

Methodologically, I must note that because I shared this information with Mary, presumably her account of her sexual relationship (which I extensively discuss in Chapter 4) would differ now than when I interviewed her. During the interview, Mary described extreme vaginal dryness and a lot of frustration because she cannot talk to her husband about how to make their sexual relationship more satisfying for her. At first, she says that she wishes the dryness would just go away. Later in the interview, she says that she wishes she could sit down and tell her husband what she enjoys during sex and what is painful, but she cannot have that type of conversation with him because her husband "is a person that's not really willing to sit down and talk one on one too much about personal feelings."

If I interviewed Mary now about her relationship, she may not characterize her sexual relationship with as much frustration because one of her wishes has been granted: her vaginal dryness is significantly reduced. However, my analysis of her account in the dissertation focuses on her relationship before she began using the estrogen cream. I do not believe that her account before using the estrogen cream is less "true" than her possible changed perspective of her relationship after using the cream. Each version would be equally "true" and would represent Mary's views of her relationship, which have changed over time. Instead, I believe that this example illustrates one of the epistemological assumptions of qualitative methodology, that social reality is dynamic and in flux.

Conclusion

In this chapter, I discussed my rationale for using qualitative methods, how I designed the study, the sample, my role in the research process and ethical issues. Throughout the dissertation I have tried to present the descriptions of the women I interviewed as accurately as possible, although I take full responsibility for the interpretation of those descriptions. After analyzing the themes and reading and rereading the quotes, I decided which selected quotes to use to illustrate those themes. This selective use of quotes inevitably risks misrepresentation. Many of the women I interviewed, however, asked me to send them copies of the dissertation upon

completion. I hope knowing that these women will read the dissertation helped me to keep as true to their accounts as possible.

Chapter 3

Menopausal Expectations and Experiences

In this chapter, I examine women's menopausal expectations and experiences. I argue that understanding women's experiences with menopause entails knowing more than how many menopausal changes women experienced. The absence or presence of menopausal changes or "symptoms" only tells a part of the story. To fully understand *how* women view menopause, how they define it, and *why* they feel the ways they do about it, I examine how cultural ideas about menopause as well as various social factors influence their expectations and experiences.

Past Research on Menopausal Expectations and Experiences

Much of the past research on women and menopause has focused on women's attitudes and expectations, rates of "symptoms" and depression. I review the relevant literature on health care utilization and HRT use in Chapter 6. With few exceptions (Jones, 1994; Martin, 1987; Winterich and Umberson, 1999), past menopause research is based primarily on quantitative surveys. Much of this research defines menopause as the cessation of menses and associates a huge range of vasomotor and emotional changes with the menopausal transition. For example, in "The Normal Menopause Transition," by McKinlay, Brambilla and Posner (1996), they define the perimenopausal transition by the following items: age (51), the number of years the transition lasts (approximately 3.5 years), and the three most common "symptoms:"

hot flashes, cold sweats and insomnia (1996). Other research includes long physical and emotional "symptom" checklists, sometimes including as many as 40-100 items. With few exceptions (see Padonu, et al., 1996; Mansfield and Voda, 1997) these checklists are overwhelmingly negative and vague (see Rostosky and Travis, 1996, for a critique of this literature).

The findings of past survey research suggests that younger women have more negative expectations and views of menopause than women who have experienced it (Avis and McKinlay, 1991; Cate and Corbin, 1992; Gannon and Ekstrom, 1993). While most women view the end of their menses positively or neutrally, those with the most negative attitudes about menopause report the most negative feelings about it and may have more health problems prior to menopause than those who view it positively (Avis and McKinlay, 1991). Furthermore, those women who become depressed during menopause tend to have histories of depression (Avis and McKinlay, 1991; Matthews et al., 1990).

Other research on perimenopausal changes suggests that most mid-life women report a range of somatic, emotional and vasomotor conditions including weight gain, fatigue, joint pain, irritability, headaches, hot flashes and vaginal dryness (Lee and Taylor, 1996; Mansfield and Voda, 1997). The research on whether these conditions are caused by hormonal fluctuations due to menopause, aging or life stressors of mid-life is inconclusive (Mansfield and Voda, 1997).

Survey research is limited to reporting on the number of times a specific perimenopausal change occurs. This methodological design reduces menopause to an individual biological event. Also, the results imply that these changes are problematic, which is not always the case. At least one study suggests that women may experience the physical changes associated with menopause as relatively insignificant when they are simultaneously experiencing urgent life stressors, such as health problems and marital crises (Winterich and Umberson, 1999). Other research suggests that hot flashes are particularly difficult and embarrassing to women in contexts where women have less power than those around them (Kittell, Mansfield, and Voda, 1998; Martin, 1987). Therefore, the hot flash in and of itself may not be problematic but, rather, the circumstances in which women have hot flashes.

Furthermore, much of this research is based on white, middle-class samples, which misses possible differences by race, class and sexual orientation. In a review of cross-cultural data on menopause, Kaufert argues that the research in the West reflects the experiences and views of the most valued members in society: "The methodological consequences are that the measures used in menopause research reflect the physical condition and experience at menopause of a highly select group of women" (1996:170). I include a diverse sample of women to begin to fill in some gaps of menopause research and to illustrate the social significance of women's menopausal experiences by sexual orientation, race, and class.

Unlike most past research on perimenopause, this study begins with the lived experiences of women (Smith, 1979) by asking open-ended questions about women's expectations and experiences. As women discussed their menopausal experiences, often they would talk about other life events such as troubled relationships, stressful family and work issues, traumatic pasts, and poor treatment from doctors. For some women, however, menopause simply means the end of their periods and they did not relate it to other events in their lives. Overall, the narratives of the 30 women in this study provide texture for understanding how women's experiences and the meanings women attribute to menopause vary and, for many women, are shaped by cultural ideas about menopause, gender and sexuality. Furthermore, understanding how women's experiences are shaped by these social factors reframes menopause from an individual experience, with HRT as a solution for difficult changes, to a social experience with a range of possibilities for how to understand and improve some women's difficult menopausal experiences.

Expectations About Menopause

Women in this study did not learn about menopause systematically through school health programs or classes. Because the public discourse on menopause is relatively recent, popular materials were not widely available either. Furthermore, most women's mothers did not share their own experiences with their daughters because of the cultural belief that this topic is too private. Therefore, perhaps it is not surprising that as I discussed expectations about menopause with women, fourteen

women overall, almost half the women in the study, describe negative expectations about menopause. Many of these women discuss "old wives' tales" or the negative cultural story of menopause as a time when women become irritable or "go crazy." Also, many women describe childhood memories of overhearing mothers and other relatives discuss menopause as a hard time and a few women describe the negative influence of the media. All of these negative expectations illustrate how the dominant cultural story about menopause becomes internalized and influences some women to expect that their own menopausal experience will be difficult.

For example, Ellen, a 53-year-old Caucasian heterosexual, says that she remembers reading articles about menopause and thinking: "Oh my gosh, some people have it so severe. And you are thinking, 'Am I going to be one that has emotions out of whack and need medication…because (of) deep depression?"

This example illustrates some problems with the limited resources available to women for learning about menopause as a diverse and varied experience. The articles that Ellen read did not contain any positive stories and the negative accounts reify the cultural construct of menopause as a problematic health time in women's lives. Understandably, then, Ellen's concerns about her own menopausal experience focused on whether she would have "it," as if menopause is an illness, "so severe," like the women she read about, and therefore would need medication.

Kate, a 57-year-old Caucasian lesbian, recounts a personal experience with depression that influenced her negative expectations and also recalls her mother's

doctors' reaction about her mother's mood swings during menopause. They became so severe that at the age of 11 or 12, Kate called her mother's doctor and said: "PLEASE do something for her. We can't stand it. Basically he said, 'Well you know how women get witchy and bitchy when they're like that. Just you kids be nice to her.'" This account clearly illustrates how cultural ideas about menopausal women as "crazy" and "bitchy" may be perpetuated through interactions with doctors. Because of this doctor's view of menopause and her own experience with depression, Kate worried that her own menopausal experience would send her into another depression.

As stated earlier, these expectations about menopause and mental illness or depression are not reflected in the research on women's menopausal experiences, which suggests that the onset of menopause is not associated with an increased risk of depression (Avis et al., 1994). Prolonged perimenopause (more than 27 months), however, is associated with an increased risk for depression, but this depression is transitory (Avis et al., 1994). In other words, once perimenopause ends, women's depression lifts. Furthermore, women who become depressed have a history of depression; therefore, their depression is only partly explained by perimenopausal changes (Avis and McKinlay, 1991; Matthews et al., 1990).

Only heterosexual women in this study describe negative expectations about menopause and sexuality. These accounts reflect the cultural link between menstruation, reproduction and sexuality. Because our society associates first

menstruation with female sexuality (Martin, 1996), some men and women may associate the last menses with an end to female sexuality. For example, two heterosexual women expected that menopause would affect their sexuality and "womanhood." Peggy, a 57-year-old African American, says that she "heard all these stories" about women having hot flashes or acting likes "witches." During childhood, she says she remembers that she would:

> …listen to my mother and my aunts and they'd be sitting there talking and they said, "Well, we're going through the change and this and that. I told that man to get away from me! I don't want him near me!" And then they'd all sit and laugh, and, of course, I'm overhearing all this (thinking), "No sex?….Does sex stop at 50?" And I did, I thought at 50…it stops.

Similarly, Martha, a 56-year old Caucasian, says that she thought menopause meant:

> ….it was the beginning of the end. Like that was the sign that you were finished with being a woman. The beginning of your period is when you become a woman, so when you're period's over, then you're sort of like not that full productive woman again.
>
> (JW): Did you ever hear your mom or anyone talk that way?
>
> No. I think I just figured that, you know, the beginning was…your period and…because that's made a big deal of, you know, you're becoming a woman when you get your first period….So, it (menopause) felt like being less of a woman.

These accounts illustrate how some women internalize the association between menopause and female sexuality, however, the findings suggest that this expectation is linked to assumptions about heterosexuality. Dominant ideas about female sexuality define women as objects of male pleasure (Connell, 1995; Martin, 1996;

Rich, 1980). Perhaps as first menstruation symbolizes women's embodiment of this cultural definition of female sexuality (Martin, 1996), menopause may represent an end to female sexual desirability. Therefore, heterosexual women may be more vulnerable to experiencing menopause as a time of sexual decline than lesbian women.

Furthermore, Martha's account highlights the consequences of the lack of a social acknowledgement of menopause as an important and positive event in women's lives. Unlike the celebration of her first menstruation, no-one gathered to celebrate her last menses. The lack of a social ritual reflects the negative social meaning of menopause in our society, that menopause is an event to hide or simply not discuss. Understandably, then, some women view menopause as an "end to womanhood."

Eleven women, over one-third of the sample, said they did not have any specific expectations or that they simply "did not think about it very much." Some of these women said: "I had no idea, really, what to expect." The fact that more than one-third of the sample did not have any specific expectations may illustrate women's lack of resources to learn about their bodies and menopause. Past research suggests that the worse aspect of perimenopause for many women was that they did not feel prepared for what to expect (Mansfield, and Voda, 1997). In this study, some women were frightened by the changes in their bodies, such as hot flashes, which I discuss in the next section.

The remaining women describe positive or neutral expectations. Their accounts as well as one woman who initially described negative expectations point to additional ways in which women's socialization about menopause could be improved to help prepare women to view menopause as more than a health issue or a time to avoid aging. For example, Sophie, a 55-year-old Native American lesbian, says that she remembers childhood stories "about women going crazy. You hear that it's like, oh, it's hell, it's the worse thing." In her 40s, however, she read, *Our Bodies, Ourselves,* a feminist health book (1984), which she remembers as saying: "If you're stable and comfortable with who you are, then you'll be fine. And I thought, 'Well, okay! It will be a breeze!'" This feminist health resource helped Sophie replace her childhood memories of old wives' tales with a positive view of menopause as a stage that she could enjoy.

Four women say that they talked to their mothers about menopause and that they assumed they would not have any "problems" with menopause because their mothers described it as "no big deal," or as inconsequential. These accounts suggest that, like menstruation (Martin, 1996), women's expectations about menopause are influenced by their discussions with their mothers or family members. When mothers prepare their daughters to expect menopause to be a normal event, daughters may be more likely to perceive menopause positively.

Summary

In summary, the socialization of the majority of women in this study about menopause did not occur systematically or positively; instead most women in this study learned about menopause through "old wives' tales" from mothers, aunts and relatives. This study suggests that some women's lack of education about their reproductive systems means that they primarily rely on the dominant cultural story to form their expectations about menopause. The underlying assumption of this cultural story is that women's reproductive systems affect their mental health and sexual functioning. Consequently, some women may internalize the negative cultural story about menopause as a time of mental and sexual decline and worry that their own menopausal experience will be difficult.

In this study, only heterosexual women associated the lack of menses with a lack of sexuality or the end of being a woman, however. This finding suggests that the cultural link between reproduction and sexuality may more negatively affect heterosexual women's expectations about menopause than lesbian women. Furthermore, women's accounts about positive expectations suggest ways that women can learn about their bodies and prepare for menopause as a normal event in their lives. Through open dialogue with their mothers or other relatives and through detailed education, women can learn to expect that menopause is a varied experience that includes positive aspects.

Menopausal Experiences

While past research (Avis and McKinlay, 1991) reports that most women view the end of menses with relief or neutral feelings, most women in this study describe some aspect of the menopausal transition as difficult or annoying. However, for some women, menopause does simply mean the end of monthly periods and they describe the transition to this stage as "no big deal." But, many women's extensive narratives about their experiences are not easily reduced to characterizations of "easy" or "hard" depending on the absence or presence of physical and emotional changes. These narratives provide texture for understanding the meaning of their menopausal experiences in their lives. In turn, my analysis of what menopause means to them points to the context of midlife, cultural ideas about menopause, and other social factors to explain the sociological significance of their experiences and perspectives. I organize my findings of women's experiences according to the following themes: rejection of cultural story, role of stress, cultural meaning of bleeding, race and medical care, and past traumas.

Rejection of Cultural Story

Eleven women describe their experiences with the menopause transition as "easy" or "not a big deal." Interestingly, however, the women in this section only describe physical changes, such as hot flashes and erratic periods, and none describe mood swings or anxiety. Also, some of these women discussed negative expectations about menopause including "old wives' tales" that women become "crazy." Perhaps

when women do not experience mood swings or anxiety during the menopausal transition, in other words, their experiences do not reflect the dominant cultural story about menopause, then they perceive the physical changes of menopause as easy or just "not a big deal."

For example, Sarah, a 58-year-old Caucasian heterosexual, said that she remembers hearing that women become "irritable" and "go crazy" during menopause, but in her case, her periods just gradually stopped. She explains that she unexpectedly got pregnant when she was 46. After she delivered this child, she only menstruated three more times in six-month intervals and stopped menstruating altogether at 47. Also, Janet, a 52-year-old Caucasian lesbian, says that she heard menopause could be "debilitating" and hoped that her own experience would not be problematic. She then says that she experienced menopause with ease: "It was like, no big deal." Leading up to her final period, she first had erratic periods, and then she had only one period when she was 49, and had her last one at 50. And, as discussed, Peggy, a 57-year-old African-American heterosexual, thought that menopause meant the end of her sexuality, but says that she "basically sailed right through." She had some hot flashes, night sweats and irregular periods for about five years and stopped menstruating at 53. Also, in contrast to her expectations, her libido increased. All of these examples illustrate how women who expected to experience menopause according to the dominant cultural story may view it as relatively easy when their experiences do not reflect their expectations.

Daphne, a 60-year-old Caucasian lesbian, offers another reason that some women may view the menopausal transition as "not a big deal." Even though she expected that women become "cranky" during menopause, and she describes her hot flashes as "embarrassing," she says that her overall experience was "rather smooth," because:

> I had had two children, I had no intention of having any more children And I didn't *buy* (emphasizes) the "I'm not a real person anymore," stuff, because, my personhood had never been totally tied to my biological functions, and, I had a profession and all these other things….

Daphne defines her sense of self as more than her reproductive status and her "biological functions." She points to the aspects of her life that give it meaning, including her career and, later in the interview, her relationship with her female partner. Therefore, for Daphne, menopause only means the end of her menses. In other words, some women may reject the dominant cultural view of menopause and femininity, which narrowly defines women's worth by their youth, sexual attractiveness and reproductive ability (Davis, 1995; Greer, 1991).

Perhaps her sexual orientation allows her to consciously reject this ideology as well. Daphne was married for 20 years before deciding to get divorced to pursue an intimate relationship with a woman. Because she actively rejected heterosexual relationships in favor of a relationship with a woman, she may have a unique vantage point to reject the dominant view of femininity (Harding, 1991), which links female sexuality with women's reproductive status. This account illustrates how, as Sandra Harding argues (1991), that thinking from lesbian women's lives provides a unique

perspective to critique the social organization of gender. Her account also offers an alternative vision of femininity, which does not link women's self-worth with their reproductive status.

In summary, the accounts of some women in this study suggest a couple of reasons why they may experience the menopausal transition with ease and view the end of their menses as "no big deal." Some women who expected menopause to be an emotionally and sexually difficult time, but do not experience mood swings or decreased libido, may view the transition as relatively easy. A lesbian openly rejects dominant ideas about reproductive status, femininity and women's worth, and defines menopause as only the end of her menses. Her sexual orientation may provide her with a unique vantage point to reject these cultural expectations about femininity.

Role of Stress

Many women in this study associate the menopausal transition with stressful life events such as health problems, troubled relationships, and deaths of family members. Similar to past research (Winterich and Umberson, 1999), some women say that menopause was inconsequential in relationship to other stressful events. However, unlike such past research, other women say that the emotional changes associated with menopause, such as mood swings and anxiety, exacerbated their ability to cope with stressful life events. These accounts illustrate how some women define menopause in relationship to stress that often occurs during midlife and some ways that women define menopause beyond the absence or presence of menopausal

changes. In other words, these accounts further illustrate *why* some women may experience menopausal changes as relatively easy or difficult.

For example, two women explain that menopause was insignificant compared to the emotional crises that they experienced during the menopausal transition. For example, Mary, a 57-year-old Caucasian heterosexual, says she had erratic periods and heavy bleeding before her last menses between the ages of 50 and 51. When she realized she was going through menopause, she says: "I didn't really give it a whole lot of thought because that's just kind of a part of aging and as a woman, you know that will be your bag sometimes." Then Mary explains all of the crises she coped with at 50. First, she was diagnosed with breast cancer and within a month was treated by undergoing a lumpectomy and radiation therapy. During her radiation treatment, doctors diagnosed her mother with ovarian cancer. A couple of months later, her brother passed away. She says that she was very "busy…you know, if you're busy worrying about other people, you don't have time to worry about yourself. You just do it and go on."

Similarly, Susan, a 58-year-old Caucasian heterosexual, says that her menopausal transition was "very mild." She had hot flashes and then "it just dried up because I think there was just so much on my plate at that time, that I probably just went through it very quickly." Susan says that the transition only lasted three to four months and she stopped menstruating at 42. She then explains the other crises in her life:

> My brother and my niece committed suicide within two weeks of each other. I have an alcoholic daughter…I was also married for the second time and he left after four months of marriage….There was just so much emotional upheaval…it was kind of like, "Who can be bothered with this?"

For the first time, Susan needed to support herself and her children. She took a job at a factory because of the high pay but endured a lot of sexual harassment.

Similar to past research, these two women view menopause as insignificant because other stressful life events were more important to them than the changes associated with menopause (Winterich and Umberson, 1999). Both women describe hot flashes and erratic bleeding, but do not perceive those physical changes as problematic because the stress with which they coped was more important. Furthermore, the stress they describe highlights how women's expected roles as caretakers may be experienced particularly intensely during midlife when divorces and family deaths occur, parents age, and they cope with their own health problems (Mansfield and Voda, 1997).

In contrast, some women explain how menopausal changes exacerbated their ability to cope with stress. For example, Ellen, a 53-year-old Caucasian heterosexual, did not expect to experience menopause until her 50s, but the chemotherapy treatment for her breast cancer caused an early and sudden menopause at 46 (Cobleigh et al., 1994; Love and Lindsay, 1997). She coped with difficult hot flashes that occurred "every ten minutes," extreme vaginal dryness, which made intercourse painful, as well as the side effects from chemotherapy including nausea, fatigue and hair loss. The physical changes from menopause and side effects from chemotherapy occurred

at the same time and the meaning of her menopausal changes represented the stress and scare of having breast cancer. Therefore, dealing with the scare of her breast cancer and coping with early menopause made the overall experience of menopause difficult for Ellen.

Other women explain how the emotional changes associated with menopause were difficult because of troubled relationships. These accounts illustrate how some menopausal women may deal with what I view as a "one-two punch" of negative cultural expectations: "You're irrational because you're a woman and you're menopausal!" As these accounts demonstrate, some women's husbands may discount their wives' emotional states because of assumptions about the link between women's behavior and their reproductive status. For example, Selena, a 60-year-old Caucasian lesbian, explains that menopause was difficult because of her unhappy heterosexual relationships. She describes the end of her 19-year marriage to her first husband who left her for a younger woman. Soon after, she became involved with an abusive man. Also, she says: "I turned off my brain…and I had this frantic urge to have a child." She married this man and tried to have a child using fertility treatment, which did not work. Selena says during this time she had mood swings, which her husband attributed to menopause. She says: "He would do something totally out-of-line, I'd call him on it, and he'd say, 'You're menopausal. You're irrational.'" During this marriage, Selena says: "I had been slowly coming out of an incredible

deep denial that I'm a lesbian." Selena associates perimenopause with all of these life events and says: "What was menopause and what was due to stressful relationships?"

Undeniably, Selena's mood swings during perimenopause overlapped with a complex set of life stressors, including questioning her sexual orientation. In the case of her second marriage, however, her husband's disrespectful reaction to her mood swings discounted her feelings about the problems in their relationship and her desire to have a baby. His poor treatment of her reifies the dominant cultural story about menopause as well as dominant ideas about femininity. In other words, the dominant cultural story of menopause attributes women's behavior to hormonal changes and dominant ideas about femininity characterize women as more emotional than men.

Similarly, Martha, a 56-year-old Caucasian heterosexual, describes the deterioration of her 30-year marriage, as well as insomnia and mood swings, which she associates with the hormonal changes of menopause. She says:

> I think the worst symptom, though, that bothered me was waking up in the middle of the night like with my eyes…like they were sown open and I couldn't close, you know, I just could lie down and then, of course, everything that was on my mind at the time would be keeping me awake. So part of that time I thought it was like just worry about this crummy marriage and my brother's death and my parents had died not long before that, worrying about all those kinds of things.

Research suggests that some women experience insomnia during perimenopause (Love and Lindsay, 1997). Martha's account illustrates the complex relationship between insomnia and stress. The hormonal changes of perimenopause may cause insomnia, which can lead to sleep deprivation, depression and irritability. But her life

crises, the deterioration of her 30-year marriage, and her brother's death, probably exacerbated her insomnia and stress.

Furthermore, her husband's belief that Martha's request for a divorce was caused by the hormonal changes of menopause illustrates how dominant expectations about menopause and femininity are reproduced through social interactions. Martha says:

> In fact, he really thought the reason we were getting divorced was because I was going through menopause….Because he just thought I was being more upset about things and if I wasn't going through menopause, I wouldn't be upset and then, therefore, I'd be tolerant as I used to be….because it couldn't be anything he was doing.

Like Selena, Martha's husband delivers a "one-two punch" of negative cultural expectations about menopausal women and dismisses her because of her reproductive status. These accounts illustrate how expectations about menopause and femininity may be reproduced through social interactions and contribute to women's difficult menopausal experiences.

The accounts in this section suggest that making generalizations about some women's experiences with menopause can be complex, particularly when difficult physical and emotional changes occur at the same time that women are coping with life stressors. These narratives provide meaning about menopausal changes for women who experience menopause as more or less difficult in relationship to stress. Furthermore, some of these accounts highlight how cultural expectations about menopause and femininity may contribute to some women's difficult menopausal

experiences. Therefore, menopausal researchers need to attend to the social context of women's experiences by specifying *how* women define their menopausal experiences, such as whether they are focusing on a particular change or comparing it to other life events, before making generalizations about women's overall menopause experiences.

Meaning of Heavy Bleeding

Several women emphasize that heavy bleeding was difficult and their accounts suggest that part of that difficulty may be linked to cultural meanings about menstrual blood. The physical and emotional aspects of dealing with heavy menstrual bleeding are undeniably difficult and annoying, especially when it disrupts a woman's quality of life. However, in our culture, women learn that menstrual blood should be private, controlled and hidden (Martin, 1987; Martin, 1996; Sasser-Coen, 1994). When women experience heavy bleeding during perimenopause, they may experience this type of bleeding as embarrassing because it is difficult to hide from others. They may experience their perimenopausal body as "breaking down" (Martin, 1987) and out-of-control as well.

For example, Margaret, a 55-year-old Caucasian heterosexual, says that the heavy bleeding during perimenopause was "very, very difficult," especially at work. She bled through large pads quickly and sometimes passed large blood clots, which "scared" her. Sometimes she would run to the bathroom and spend considerable time waiting for the bleeding to subside. Similarly, although Mary says that she did not

have time to focus on menopause because of the crises in her life, she described heavy bleeding as "annoying" because, sometimes after meetings, she would stand up and "then…immediately have to run to the ladies' room."

These accounts illustrate the difficulty of controlling heavy bleeding, especially at work, and suggest why some women may view this aspect of perimenopause as hard. Women learn during first menstruation that they should hide menstrual bleeding from others (Martin, 1996), which is a difficult feat for women who experience sudden and heavy bleeding during perimenopause. This expectation stems from the cultural view of menstrual bleeding as a private bodily function that women should control and keep private (Martin, 1987; Martin, 1996; Sasser-Coen, 1994). These accounts suggest that women may experience heavy bleeding as particularly difficult, in part, because of this cultural expectation.

Race and Doctor Treatment

Race appears to play a role in some women's problematic experiences with menopause. Five women overall explain that menopause was difficult because they did not know what was happening with their bodies when they began having hot flashes and/or spotting. And when each of them consulted their doctors, their doctors dismissed their concerns. Four of these women are women of color.

For example, Chiyo, a 64-year-old-Japanese American heterosexual, moved to the United States when she was 50, at the same time she began having hot flashes. When she described the heat sensation to her mother and sisters, who lived in Japan,

they said: “I have no idea what you’re talking (about).” As discussed in the first chapter, hot flashes are not as common in Japan as they are in the United States and Canada (Lock, 1993). Then she consulted a doctor, an internist, who said: “Well, (it’s because) you come from a different place, maybe you’re adjusting.” When she was 52, the hot flashes became more intense. During an exam with a second doctor, a gynecologist, Chiyo told him:

> “I’m having very hot, hot, hot spells.” Then he laughed. He says, “What’s new?” I said, “That’s new to me because, you know, I’ve been sweating….” So he said, “Because it’s the summer, you know, you’re hot.” I said, “It’s not that.”

After more discussion, her doctor finally said, “Probably, it’s a hot flash….Would you like to take a hormone pill?” Chiyo describes these interactions with frustration. The first doctor attributed her heat sensation to the fact she moved from another country. The second doctor appears to treat her with condescension; whether this doctor’s treatment stems from prejudice toward Chiyo or minorities in general is difficult to determine. However, past research suggests that white, middle-class doctors treat minorities with more authority and less respect than their white patients (Boston Women’s Collective, 1998; Strauss, Anselm, 1979).

Similarly, Andrea, a 49-year-old African-American lesbian, says that she did not know that the spotting in between periods when she was 43 or 44 was due to perimenopause. She also started having hot flashes and says she was “scared to death” because she did not know what was wrong with her. When she asked her doctor about it, she said that: “Nothing (was) wrong with me, (that it was because of)

stress….and I got really scared. And that went on for a long time, maybe a year or two." Andrea's aunt helped her figure out what was happening with her body. She gave her Sheehy's book and said: "I think you may be experiencing this." Andrea says that reading this book helped "calm" her and she went back to her doctor and insisted on a blood test to find out whether she was perimenopausal.

Andrea's experience reflects past research, which suggests that African-American women rely on social support for help with menopause more than doctors (Padonu et. al, 1996; Pham, Freeman, and Grisso, 1997). In Andrea's case, however, she tried to consult with a doctor but did not find her diagnosis helpful. Similarly, Angie, a 51-year-old African-American heterosexual, first consulted with a doctor at a clinic because she had "suffocating" hot flashes and erratic periods. The doctor said: "Oh, you're not going through menopause. You just need help to get your period back." Angie found this advice confusing and went to a pharmacy to buy vitamin supplements for menopausal women. These accounts suggest that African-American women may rely on social support for help with menopausal concerns rather than their doctors because they receive unsatisfactory treatment from their doctors.

Also, these accounts suggest that doctors' dismissal of women's concerns about hot flashes and erratic periods contributed to their anxiety about the changes in their bodies. The fact that four women are of color may illustrate how gender and race interact for women in the doctor-patient interaction. Past research suggests that

women feel that some doctors dismiss women's concerns as "all in their head" (Ehrenreich and English, 1979) and other research suggests that white, middle-class doctors treat minorities with less respect and more authority (Boston Women's Collective, 1998; Strauss, 1979). This finding illustrates how women of color suffer from oppression from their multiple sources of "marginalized identity," as women and as people of color (Collins, 1991; Lorde, 1983). The accounts from this study suggest that these multiple sources of oppression can contribute to some women's difficult menopausal experiences through the doctor-patient interaction.

Traumatic Past

Two women discuss their abusive sexual histories and describe how they experienced flashbacks to these terrible memories during menopause. These accounts illustrate another reason why hormonal changes and mood swings associated with menopause may be experienced as particularly difficult for some women.

For example, Kathy, a 56-year-old African-American lesbian, endured a lot of sexual abuse as a child from both men and women. Kathy says that during menopause she had anxiety attacks and fears as well as hot flashes and erratic periods. The anxiety, however, was particularly difficult. She describes her abusive past:

> My stepfather hired this young man to work with him, and you're young, I mean, when you're in the country, people just put kids all together….So this guy was in the room with me and he used to rape me and I was five, he was about 15. But I also had incest that was done on me by an aunt, her son. I mean it was a lot. I was abused a lot as a child.

(JW: By men and women?)

> Yea, and my mother was 14 when she had me, and she was raped, and so I'm a product of rape….And I think the menopause, even though I had worked on it a lot, I think the menopause like magnified so much of that stuff, that it was my fault. I must have did something wrong.

During this time, she consulted a therapist and says that during therapy, she dealt with:

> My memories of my abuse and incest…it was like digging them out because you get threatened that…if you tell, you're gonna get hurt or you're gonna get killed…so you don't, you just bury them. You cover it up with whatever. In my case, it was food.

Although Kathy says that she participated in a 12-step program for compulsive eating and sought counseling before she became menopausal, the anxiety she experienced as she went through menopause may have triggered these memories of her past.

Similarly, Nancy, a 60-year-old Caucasian lesbian, says that when she began menopause, she had mood swings, heart palpitations and anxiety attacks. Nancy does not explicitly link her anxiety during menopause with her past sexual abuse like Kathy does. But after she describes her experiences with menopause, Nancy describes the anxiety attacks she first experienced at age 17 in the same way she describes her anxiety during perimenopause. She describes the childhood traumas that gave her anxiety attacks:

> I was pregnant when I was 11. I was raped when I was 11. I had twin boys. Yea, and they both died. They lived for about three days and then they died. They were premature.
>
> (JW: I'm so sorry).

> That's okay. Yea, I went through therapy because, see I was brought up in a foster home when I was young, because my parents were in the war. My mom had two children already and she had my sister and I, which she couldn't keep, so we were in foster homes up until, probably, I was nine or 10 years old. So it was a big—when I came back to them, it was very, very difficult to adjust to family life again. And…when I did come back, I was raped when I was about 11….And going through that, and I had a lot of things stirred up in my brain that I would guess would affect my relationships, and I didn't know why. So I went into therapy, and we talked about it, and it brought a lot of things back. And I was having almost, I guess flashbacks of that, and when I'd have the flashbacks, it was almost like a panic attack. And I never said anything to anybody because I thought I was nuts….

Nancy sought therapy in her late 40s, the same time she first noticed heart palpitations and anxiety attacks. Perhaps Nancy's anxiety during perimenopause triggered memories of her childhood traumas in the same way as it did for Kathy.

These accounts illustrate how some women may associate emotional difficulties during the menopausal transition with their traumatic past. Although these two examples are based on lesbians' experiences, studies suggest that women from all races, classes and sexual orientations suffer from sexual abuse and incest (Boston Women's Collective, 1998). Some psychological research suggests that children may suppress memories of sexual abuse and trauma as a coping mechanism (Boston Women's Collective, 1998). Perhaps, as these accounts suggest, some women who have suffered abuse find that the emotional swings and/or anxiety during perimenopause trigger memories of that abuse, which may contribute to a more difficult menopausal experience overall.

Summary

In summary, the accounts of the 30 women in this study suggest that women's experiences are not easily characterized as easy or difficult and cannot be fully understood in terms of the absence or presence of the physical and emotional changes associated with menopause. Reducing women's menopausal experiences to "symptom" rates overlooks the meaning of those experiences. In other words, that approach misses the why, the social context and social significance of women's menopausal experiences. The findings from this study illustrate the social meaning of women's menopausal experiences, which are linked to cultural ideas about menopause and menstrual blood, and sexuality, as well as midlife stress and past abuse. These accounts also highlight the roles of gender, race and sexual orientation for some women's experiences.

Consequently, these findings point to social arrangements as problematic for some women's perimenopausal experiences and illustrate why some women's difficult experiences are not easily solved with a hormone pill. Taking hormone therapy does not, for example, address women's lack of education about menopause and their bodies, does not overcome the expectation that women should hide heavy bleeding, and does not address the poor treatment some women of color receive from doctors. Indeed, prescribing hormone therapy for menopausal women bolsters the dominant view that hormonal changes explain women's behavior and feelings. In contrast, the narratives in this study illustrate how women's menopausal experiences

are shaped by social factors, which broadens researchers understanding of how to improve those experiences.

Hot Flashes

Many women in this study describe unpleasant hot flashes. Even though hot flashes are commonly associated with perimenopause, premenopausal women and men can have hot flashes too. For example, men who are treated with estrogen for prostate cancer may have hot flashes when the treatment stops (Love and Lindsay, 1997). However, because a hot flash is the most common physical change that Western women describe in research on menopause (Mansfield and Voda, 1997), hot flashes are commonly associated with menopause.

Medical researchers are not completely certain why hot flashes occur but believe the part of the brain that controls the body temperature becomes readjusted. The brain sends messages to the body to cool down as if they body's core temperature was suddenly turned down 20 degrees. The body interprets the 98.6 temperature as too hot and tries to cool itself to the readjusted core temperature. Therefore, hot flashes occur because a person's body is attempting to cool itself (Love and Lindsay, 1997).

In this section, I analyze why some women experience hot flashes as difficult or embarrassing. This analysis highlights how hot flashes are linked to cultural meanings about menopause, gender and sexuality. Most women in this study say that

they had or are having hot flashes, which reflects past research which reports that 50% of women have at least one hot flash within a year of their last period (Avis and McKinlay, 1991). Women's descriptions vary from a mild heating sensation to overwhelming heat and perspiration. Regardless of the heat intensity described by women, many of them describe hot flashes as "embarrassing" or "annoying" for various reasons.

In particular, many women say that hot flashes are difficult at work and in public spaces because they feel out of control and others can see their perspiring, flushing faces. For some women, hot flashes represent an internal disorder, that something is wrong, as well as feeling out-of-control. As Emily Martin explains, the feeling of turning red during a hot flash is similar to the sudden sensation of turning red when embarrassed (1987). Also, female bodies and issues of reproduction are historically associated with the private sphere (Martin, 1987). When women have hot flashes, turn red and perspire, they may experience this lack of control over their bodily functions as particularly distressing in public settings, which are conceptualized as arenas for disembodied, male workers (Martin, 1987). In Martin's study, she suggests that hot flashes are particularly difficult for women at work and may be linked to how much power women have at work. In other words, the less power a woman has, the more difficult her hot flashes are.

In contrast, this study suggests that women experience hot flashes as difficult or embarrassing in public arenas, whether at work or other public areas. I argue that

women's views are a reaction to the cultural view of menopause as an unpleasant time in a society that devalues aging women. When a woman has a hot flash, it is a public symbol that she is an aging, midlife woman at the end of her reproductive years. Women may experience this public exposure of their bodily functions as embarrassing because of the cultural devaluation of menopause and aging. In this study, many women's descriptions about hot flashes centered on issues of privacy, control and internal disorder.

For example, Mary describes a recent hot flash she had during choir at church. She describes it as "distracting" because "it's a personal thing" and "it's something that you don't want to shout to the world: Yea! I'm having a hot flash!" And Beth, a 54-year-old Caucasian heterosexual, says that hot flashes are "embarrassing" because: "It must not look very good, or strange or something…and nobody says anything. You're wondering what they're thinking…."

Similarly, Daphne, a 60-year-old Caucasian lesbian who is a professor, says that she did not have many hot flashes in public settings but remembers a particularly difficult one during class. Her account also illustrates issues of control and public exposure:

> I had one in a class once, where I just started sweating and I just, uh, excused myself from the class. Because I was so (sighs) disconcerted by it myself that I didn't, couldn't pay attention to what I was supposed to be doing, and it was toward the end of class in any case….But you get so red, I mean, it's not just that you sweat. People can see that there is something wrong and will ask you.

Daphne's account illustrates why hot flashes can be experienced as embarrassing. Like Mary and Beth, she suggests that she felt distracted and out-of-control when she suddenly began sweating during class. Furthermore, she knows that the students will assume that something is "wrong," rather than understand her body is undergoing a normal physiological function at this time of her life. Therefore, she wants to avoid their questions or stares. She abruptly ends the class early so she can minimize the public exposure of her private, bodily function.

Similarly, Marcia, a 48-year-old Hispanic lesbian, says that hot flashes are embarrassing because she assumes that others wonder what is wrong with her when she suddenly starts sweating. She recalls this example:

> The most embarrassing part of it all is being on a transport—going home on a bus—and praying that you don't break out in a flash. You know it's going to be a bad one when you can tell it's coming and you just sweat buckets and there's nothing you can do. It could be minus 22 and you're just like (fans herself) and everybody's staring at you like, "What's wrong with this woman?"

These accounts illustrate the cultural assumption that hot flashes represent something "wrong," that they are a public symbol of an internal disorder. In other words, if our society viewed menopause as a time when women find new sources of energy and experience postmenopause as a time of "zest," as anthropologist Margaret Mead claimed (Love and Lindsay, 1997), then women may experience hot flashes with greater ease or enjoyment. But, because menopause is associated with women's private reproductive functions and is not culturally valued, women may experience hot flashes as embarrassing.

Barbara, a 55-year-old Caucasian heterosexual, worked in a cubicle at a warehouse for a non-profit group which distributes food when she had hot flashes. Her account suggests another reason why some women, perhaps heterosexual women in particular, may find hot flashes embarrassing around men. She explains:

> I worked in a cubicle situation at the time when it started, so everybody around me knew what was going on too. And I worked with a lot of guys…at the warehouse…(and) there were big burly guys who I didn't want to share any of this with….These are young guys, who wants to share your personal life with these guys?….It's a signal about age. It's a signal about where you are in life. It's a signal that, "Well, gee, you must have had your kids kind of old, because they're young" (laughs).

Barbara's account illustrates how the cultural assumption that aging is negative and something to hide may affect women's experiences with hot flashes. Turning red and perspiring not only makes public a private bodily process, but also "signals" to those around her that she is a midlife woman. She finds this signal particularly embarrassing around young men, perhaps, because as a heterosexual woman she has internalized the cultural value of looking young. Her hot flash blows her cover, so to speak, and makes explicit that she is a middle-aged woman.

Women in this study explain why they find hot flashes embarrassing and annoying and their accounts reflect cultural meanings of the menopausal, aging female body, reproduction and sexuality. Specifically, these accounts illustrate two points about the social meaning of hot flashes for some women. First, hot flashes may be experienced by some women as distressing in public settings because of cultural assumptions about female bodies. A hot flash signals to those around a

woman that she is an embodied female of an advancing age and post-reproductive status. This signal may be embarrassing to women because private bodily functions, in particular the female body and reproduction, are associated with the private sphere. Second, because aging women are devalued within our society (Greer, 1991; Lorber, 1997) and young, female bodies are associated with beauty (Davis, 1995), hot flashes represent a public symbol of a woman's status as a midlife and aging women. The findings suggest that heterosexual women in particular may experience hot flashes as embarrassing if they have internalized dominant cultural standards of beauty and age.

Conclusion

This chapter examined how dominant cultural expectations about menopause and various social factors influenced women's expectations about and experiences with menopause. Overall, the findings suggest that the negative cultural discourse about menopause is reflected in many women's expectations. This discourse or "old wives' tales" is based on associating women's reproductive functions with their mental health and sexuality. The findings also suggest ways to improve women's socialization about menopause so that they can expect it to be a positive, normal event in their lives.

For women's menopausal experiences, the findings suggest that the social meaning of these experiences is shaped by the context of midlife stress, the cultural view of menstrual bleeding, race and poor treatment by doctors, and past sexual

abuse. Some women's positive experiences reflect a rejection of the dominant cultural story about menopause, however.

The accounts on hot flashes suggest that many women experience them as embarrassing, especially in public settings, because of hegemonic beliefs about aging women and reproduction. The findings suggest that heterosexual women who have internalized dominant ideas about gender, sexuality and age may find hot flashes particularly embarrassing because hot flashes signal their advancing age and post-reproductive status to others.

This chapter focused on women's expectations and experiences with changes associated with perimenopause. During and after menopause, women may notice other physiological changes, such as vaginal dryness and libido changes. The next chapter examines women's experiences with these peri- and postmenopausal changes to understand how social expectations about menopause, gender and sexuality influence how women perceive these changes for their midlife sexuality.

Chapter 4

Sex and Intimacy

Many women in this study say that they experienced physiological changes relevant for sexual functioning, such as vaginal dryness, and libido and orgasm changes, during and after the menopausal transition. In this chapter, I analyze the social meaning of these changes. I argue that like hot flashes and mood swings, the presence of these changes in themselves is not necessarily problematic for women's sexual functioning. Instead, my analysis illustrates how social factors shape the meaning of physiological changes for women's sexual functioning.

Past Research on Menopause and Sexuality

The scant research on perimenopausal women and sexuality suggests that their sexual functioning does not change significantly (Morokoff, 1988). However, past biological and psychological research suggests that the cessation of menses is associated with decreased sexual functioning; most women report some change in sexual desire and activity after menopause (Leiblum, 1990; Mansfield and Voda, 1995; Morokoff, 1988; Puretz and Haas, 1993). In an extensive review of the biological and psychological research on the role of menopause on women's sexuality, Morokoff concludes that although the research is inconclusive, it strongly suggests that postmenopausal women have decreased sexual functioning, including decreased frequency of sexual activity, decreased desire, decreased frequency of orgasm and decreased vaginal lubrication (1988). However, whether women's

changed sexual functioning is due to estrogen levels, spouse's health problems or other psychosocial factors, such as women thinking of themselves as less sexual after menopause, is not known (Morokoff, 1988).

Other researchers also speculate that psychological and social factors rather than hormonal changes may account for decreased sexual activity with age (Leiblum, 1990; Mansfield and Voda, 1995). For example, sexuality research suggests that marital length predicts less sexual activity; married couples engage in less sexual activity over time (Blumstein and Schwartz, 1983; Rubin, 1990). Furthermore, Barbach points out that women's sexual activity levels may decline as they age because of husbands' health problems or lack of available partners (1993b).

One limitation with most menopause and sexuality research is the heterosexist bias in the research design because it measures sexual activity through frequency of intercourse (Masters and Johnson, 1966; Pringle, 1992; for review of sexuality research, see Grambs, 1989; for menopause and sexuality see, Leiblum, 1990; Morokoff, 1988; Mansfield, Voda and Koch, 1995; Puretz and Haas, 1993). Such research overlooks other ways of having sex. Consequently, a heterosexual woman may have painful intercourse while a lesbian woman may reach orgasm through intimate touching. Some survey research would count the heterosexual woman as sexually active and inaccurately label the lesbian woman as sexually inactive.

Most general menopause research is based on heterosexual samples as well (Avis and McKinlay; 1991; Gannon and Ekstrom, 1993; Lee and Taylor, 1996;

Leiblum, 1990; Mansfield and Voda, 1997; Mansfield, Voda and Koch, 1995; Morokoff, 1988; Holmes-Rovner et al., 1996). In contrast, a unique study on lesbians' postmenopausal sexual relationships suggests that lesbians are more "life affirming and zestful" about their sexuality than heterosexual women (Cole and Rothblum, 1991). The type of sex women have may affect whether vaginal dryness is problematic for their sexual relationships. For example, Cole and Rothblum argue that lesbians focus less on penetration than heterosexual women for whom intercourse is the "main event" (1991). Furthermore, a male partner's expectations about menopause as a time of physical and sexual decline may differ from those of a female partner, who may resist negative cultural expectations about menopause (Cole and Rothblum, 1990). By neglecting to include lesbians in samples, researchers may be overlooking the influence of the social context of women's intimate relationships.

Until researchers learn how women *feel* about their sexual desire and activity levels after menopause, they cannot know whether to characterize these levels as dysfunction or normal (Mansfield, Voda and Koch, 1995). Indeed, in a recent qualitative study, two women, a heterosexual and lesbian, said their sexual interest decreased after menopause and that they *welcomed* this stage of "calmer" sexual desire (Winterich and Umberson, 1999). Also, a few studies which examine mid-life heterosexual women's definitions of sex suggest that some heterosexual women view sexuality more broadly than intercourse, including hugging, kissing and intimate

touching (Conway-Turner, 1992), relationship closeness (Hurlbert et al., 1993), and masturbation (Barbach, 1993b).

In this study, I examine heterosexual and lesbian women's accounts on sexuality to understand how cultural expectations about menopause, femininity, and heterosexuality influence the meaning of menopausal changes for their sexual functioning. In addition, I examine the role of social factors including the status and quality of sexual relationships, sexual orientation, definitions of sex and sexual history. I examine women's sexual agency as well. I do not argue that biological changes play an insignificant or irrelevant role for women's sexual functioning. Instead, I focus on how heterosexual and lesbian women interpret these biological changes for their sexual functioning.

Most of the respondents say that they noticed vaginal, libido and orgasm changes. The findings strongly suggest that the meaning of these changes for women depend primarily on the status and quality of their relationships. Therefore, I organize my findings based on women's descriptions of their postmenopausal sexual relationships according to the following categories: satisfying sexual relationship, unsatisfying sex in relationship, and no sex with a husband or partner. I did not ask each woman to classify her sexual relationship as "satisfying" or "unsatisfying;" rather, I use these categories based on the patterns that emerged from my data analysis.

In the conclusion, I discuss women's perspectives on sex and intimacy. Most women in this study define intimacy more broadly than sex and say that feeling intimate is important for a fulfilling relationship. These accounts suggest that researchers should broaden their definitions of sex to gain a richer understanding of how midlife women view sexuality and intimacy (Morokoff, 1988; Mansfield, Voda and Koch, 1995).

Satisfying Sexual Relationship

Seven women, four heterosexual and three lesbian, describe satisfying sexual relationships. Most of these women experienced vaginal dryness. However, these women describe the dryness as inconsequential for their sexual functioning because of the quality of their relationships. In addition, they all use either HRT or a lubricant, which helped to alleviate the dryness. One woman describes a smaller vaginal opening and several describe libido and orgasms changes. Regardless of which change women describe and whether they attribute it to menopause, all of these women describe happy and fulfilling sexual relationships and provide examples of women openly discussing and acting on their desire. One woman's partial life history account also illustrates how she overcame the constraints associated with dominant ideas about femininity and female sexuality to develop sexual agency.

For example, Sandy, a 57-year-old Caucasian married for eleven years to her second husband, comments about her sexual relationship: "I don't think really that

could be any better." Sandy started taking hormone replacement therapy when she first became postmenopausal, so she says that she does not have problems with vaginal dryness or orgasm intensity. However, her libido has decreased, which she initially attributes to HRT. She says: "Yea, but I was great before then. But I started taking the pills and after like a year or so, I really didn't have the desire…(before then) it was all the time." Sandy also says, however, that her poor body image may play a role too: "If I see me in the mirror, that takes my desire away," which makes her husband "mad" because he says that she is beautiful.

Sorting out whether HRT or her body image affects Sandy's interest is difficult. Although her doctors tell her that HRT should help her libido, not diminish it, some research suggests that progestin may adversely affect women's libidos (Love and Lindsay, 1997). Even though her poor body image may contribute to her lack of sexual desire, this account also suggests that the medical assumptions about the benefits of HRT may actually adversely affect some women's sexual interest.

As she discusses her changed libido since menopause, she recounts her lack of knowledge about female pleasure in her past. Her account illustrates how dominant ideas about femininity and female sexuality constrained her attempts to develop sexual agency, but she persevered and now enjoys orgasms in her current sexual relationship. Her account illustrates some problems with women's sexual socialization as well.

Sandy's says that she never had an orgasm until she was 28 or 29, after her three children were born. She tried asking her doctor about it when she was 28, she says:

> I never had one until I was like 28 years old. So I didn't know what they were. That's funny too because I asked the doctor and he just said I was 28, was having kids….and he said, "Oh, don't worry about it." I was totally clueless…And the doctor sure didn't tell you anything about anything. Your sisters, you didn't ask, because that's the way it was. You didn't ask your mother.

Sandy read some books to find out "what causes it, what happens. Then finally it happened….I always have to manipulate him (her first husband) in a position for me to have an orgasm…But with (her second husband) it's always been different, and it always just happens." She and her second husband openly discuss sex and have sex about one to two times a week.

Sandy's experience illustrates how her generation's sexual socialization did not include an opportunity for women to learn about female sexual pleasure. She did not feel comfortable asking her sisters or mothers because "that's the way it was." In other words, because she internalized hegemonic cultural beliefs about female sexuality, which construct the topic of female orgasms as "too private," she turned to a medical professional. In turn, the doctor, who may have internalized the same cultural beliefs about female sexuality, felt embarrassed and therefore did not give her any information.

This account illustrates how cultural assumptions about female sexuality ignore female sexual pleasure. Although sex education is included in school

programs today, that education does not include topics on female sexual desire and pleasure and, instead focuses on how to avoid pregnancy and sexual abuse (Martin, 1996). As this account illustrates, this narrow cultural view of female sexuality constrains women's abilities to learn about sexual pleasure.

Sandy's account also illustrates how a heterosexual woman actively learned about her body and sexuality and proactively participated in sex so she could climax. Although she faked orgasms with her first husband, now she only has sex when she is interested and never fakes orgasms. This account illustrates how a heterosexual woman developed subjective knowledge about her body as well as female sexual agency (Martin, 1996).

The rest of the accounts illustrate how the high quality of women's relationships helped them manage physiological changes associated with menopause so that can enjoy their sexual relationships. For example, Anna, a 56-year-old Caucasian married for 35 years, says that she and her husband openly discuss sex, which helped her to solve how to alleviate her vaginal dryness. He supported her decision to talk to her nurse practitioner for advice. Anna now uses Astroglide, a vaginal lubricant: "That stuff is great. I highly recommend it."

Anna describes her husband's views on Astroglide and describes her sex life as better than ever since she started using it:

> He was actually happy that I talked to her (nurse practitioner) about this stuff because he said he didn't know anything about it—the Astroglide and all that. So he was very happy because it has made it much better and actually sex is great, sometimes better now than you know. I think it's better a lot of time

> now than it was at times when we were younger….you don't have to worry about getting pregnant. You don't have to worry about someone coming in and finding you.

Anna says that she and her husband may not have sex as often, perhaps about "once a week and sometimes more," but "when you have it, it's better." Even though Anna experienced vaginal dryness after menopause, the quality of her relationship helped her to discuss openly her physical discomfort. Her husband supported her decision to consult medical help and is comfortable using the lubricant. Anna's account suggests that the meaning of vaginal dryness for her sexual relationship is shaped by the quality of her relationship and the context of midlife. For example, she enjoys sex more now than when she was younger. Becoming postmenopausal means that the fear of pregnancy is removed. Also, Anna's children are young adults and live on their own; therefore she and her husband can relax without fear of interruption. Her account illustrates a positive example of a heterosexual woman openly discussing her desire and finding pleasure in sex.

Also, Sophie, a 55-year-old Native American lesbian, who has lived with her partner for a year and a half, has noticed vaginal dryness and a smaller vaginal opening since menopause. These changes cause mild discomfort with penetration. She and her partner openly discuss everything and regarding their sexual relationship, Sophie says: "I think it's absolutely fabulous because it's honest, we both participate, we both want to satisfy the other. It's really good."

Her partner records every time they have sex in her daily planner and rates their sex with a star system. Sophie says that, according to her partner's planner, they have sex about five times a week. Regarding her sexual drive, Sophie says: "We both have a ferocious sexual appetite." She says that her orgasms have "intensified" and that sometimes they will both have an orgasm at the same time without touching each other. She says: "We have been in the process of making love and just held each other and both of us had orgasms at that moment. It's like WHOA, yea….it just goes to show that it's a loving energy that's going through."

Like Anna, Sophie's account illustrates how relationship quality can shape the meaning of menopausal changes for sexual relationships. Despite her smaller vaginal opening since menopause, Sophie describes postmenopausal sex as "absolutely fabulous" because she says that she and her partner communicate with each other about what they enjoy in sex and are willing to change their sexual activities to ensure they give one another sexual pleasure.

Finally, Kathy, a 56-year-old African-American partnered for 13 years, describes a positive relationship and an active and enjoyable sex life. She noticed vaginal dryness after menopause, which was alleviated with HRT. Recently she stopped taking the hormone therapy, but has not noticed problems with dryness. But, regarding orgasms, she says that since menopause "it takes longer to get there." However, she and her partner take their time to try and help each other "get there" and that their sex "usually ends with orgasms." In other words, this account also

illustrates how the quality of a relationship can alleviate changes associated with menopause. Kathy and her partner take more time and communicate openly about their preferences to ensure that they both climax during sex.

The accounts in this section illustrate how relationship quality can positively shape the meaning of menopausal changes. Even though most of these women experienced vaginal, libido, and orgasm changes, they discussed these issues with their partners and changed their sexual repertoire to allow more time to lubricate and climax. Also, the women's accounts in this section illustrate female sexual agency because they provide examples of women actively learning about, discussing and acting on their sexual desire (Martin, 1996). One woman's account illustrates the constraints associated with dominant ideas about femininity and female sexuality that she overcame to develop subjective sexual knowledge about her body and to experience sexual pleasure.

Unsatisfying Sexual Relationships

Ten women, seven heterosexual and three lesbian, describe problems in their current sexual relationships. Many of these women have vaginal dryness and many also describe libido and orgasm changes as well. Even though all of the women in this section describe problematic or unsatisfying sexual relationships, how women handle these issues in their relationships differs by sexual orientation. Therefore, in this section, I divide the discussion of problems in sex by sexual orientation.

Heterosexual Women: Focus on Intercourse

One reason most of the heterosexual women describe vaginal dryness as problematic in their current sexual relationships is because of the focus on intercourse in sex rather than intimate touching or oral sex. These accounts also illustrate how dominant ideas about heterosexuality, femininity and masculinity affect women's sexual enjoyment.

For example, Jane, a 61-year-old Caucasian married for 40 years, has vaginal dryness and says that: "Intercourse is definitely a little less fun, unless there's a lot of foreplay." Although she has not tried a lubricant, she says that she is "looking into some of the hormonal creams" because the vaginal dryness is a "nuisance." In the meantime, she says that she and her husband usually do not take longer for genital stimulation, which would also help alleviate the dryness.

Jane's account about her greater difficulty reaching orgasms and her diminished libido since menopause illustrate the complex relationship between biological and social factors for understanding women's sexual functioning. Jane says that she has noticed that reaching orgasm takes longer which she attributes to the hormonal changes of menopause. However, she does not attribute her decreased interest in intercourse to menopause. Instead, she says she just does not "happen to think about it." Jane's account suggests that vaginal dryness supports the domino effect theory (Morokoff, 1988; Mansfield, Voda and Koch, 1995), which hypothesizes that one physical change leads to another and consequently affects

sexual interest. In other words, less lubrication leads to longer time to climax, which may affect sexual interest. However, the context of Jane's relationship and past sexual experiences illustrate the complex interplay between menopausal changes and social factors for understanding women's mid-life sexual functioning. Her account suggests several reasons why her libido has decreased, and these various reasons illustrate the influence of sociocultural factors on physical changes after menopause.

Jane says that she takes longer to reach orgasm since menopause but, since the beginning of her marriage, she never had orgasms with her husband until "last year or so." Now she climaxes during "foreplay or close play" (intimate touching after intercourse), but never intercourse. She first noticed through self-stimulation that her orgasms take longer since menopause. Jane reflects on two incidents from her past which may affect her ability to climax with her husband. One involved embarrassment from a parental reprimand while she unconsciously masturbated as a child while reading. The other incident concerns the first time she climaxed, through an early sexual experience with a boyfriend. She says that she "didn't know what was happening and it was scary." She speculates that these past incidents may have affected her ability to reach orgasm with her husband.

In response to my question whether her husband noticed her recent ability to orgasm, she says: "I don't know because I think he may well think I do more times than I do…I wouldn't say (I'm) misleading him, but letting him think that it may happen more often." Jane says she lets him think her orgasms are more frequent to

protect his feelings. In addition, Jane and her husband never talk openly about sex because: "He's a little old fashioned and you just don't talk about things like that much."

Therefore, the menopausal changes of vaginal dryness and longer time to orgasm, Jane's sexual history, and Jane's and her husband's difficulty discussing sexual issues may more fully explain her less interest in sex after menopause. Her account suggests several reasons why her libido has decreased and these various reasons illustrate the influence of sociocultural factors on physical changes after menopause. In contrast, the domino effect theory does not take into account social factors; instead it focuses on the cascading effect of physical changes on emotional states in a social vacuum.

Jane's account on vaginal dryness and orgasms, and her sexual history illustrate two theoretical points about female sexual agency and heterosexuality as well. First, her childhood reprimand for masturbating and her first unpleasant experience with an orgasm highlight some problems with women's sexual socialization. Jane's mother taught her that finding pleasure in her body is "wrong;" her experiences may be representative of her generation's sex socialization (Barbach, 1993), although recent research suggests that most adolescent females do not masturbate (Martin, 1996).

Jane's first experience with an orgasm illustrates an unfortunate consequence of some women's lack of knowledge about sexual pleasure. Instead of enjoying the

sensation of orgasm, she felt frightened and confused about what was happening in her body. Although her early socialization limited her sexual agency, a college course educated her about female sexual pleasure by teaching her about the benefits of masturbation. Since then, Jane masturbated "on and off" and had orgasms.

The second point her account illustrates is the role of gender in heterosexual relationships. Jane says that she led her husband to believe that she enjoys intercourse more than she does to protect his feelings and because she feels "bad for him." The fact that Jane feels "bad" suggests that she has internalized the importance of sexual performance for heterosexual men's masculine identities. In other words, Jane assumes that her husband will feel inadequate if he knows she does not climax through intercourse, so she pretends to climax to protect his feelings. Jane's account reflects the dominant cultural story about heterosexual sex, that intercourse is the "main event" (Cole and Rothblum, 1991). By pretending that intercourse is satisfying, Jane is following heterosexual norms and confirming dominant ideas about femininity, which emphasize passivity and deference to men (Connell, 1987; Lorber, 1993). This account illustrates how some women may internalize heterosexual norms and recreate these norms through sexual interactions. In the process they bolster dominant cultural ideas about gender and heterosexuality.

Similarly, Mary, a 57-year old Caucasian married for 38 years, discusses extreme vaginal dryness and bleeding due to changed estrogen levels after menopause, which clearly affect her enjoyment of and interest in sexual intercourse.

The context of her relationship and her sexual orientation, however, more fully explain her feelings about mid-life sex. Her account illustrates how cultural ideas about menopause and femininity, and heterosexual norms may limit her sexual pleasure.

Mary had breast cancer, which means she cannot take HRT to alleviate her vaginal dryness because HRT increases the risk of breast cancer. In part, because of the vaginal dryness, Mary has not enjoyed her sexual relationship; she says:

> It was better back when I was younger before menopause hit….I do have a lot of vaginal dryness…and I have bleeding as a result of intercourse and it's sometimes painful. You know when something is painful, it's just not a fun thing to do and it causes problems.

The dryness has affected her interest in sex and her ability to orgasm; she says: "I mean your interest really wanes when it's painful….with me they (orgasms) are less intense and when it's painful, they're non-existent." Mary contextualizes the meaning of these menopausal changes when she discusses her husband's reaction to her pain, which illustrates the role of dominant ideas about menopause, gender and heterosexuality. She says her husband is:

> …frustrated. When he realizes that he's causing me pain that doesn't make him happy either. So you know his way of dealing with it, he'll make little comments about he wishes I'd soon get through this and become a normal person again. Well that just isn't going to happen.

Mary also says she cannot talk to her husband about sexual issues because:

> My husband is a person that's not really willing to sit down and talk one-on-one too much about personal feelings. I mean he would just be appalled to be asked very, very personal questions. And I'm not sure that he would be even

> truthful and it makes it very difficult to sit and talk about how I'm feeling and what we can do to make it better and all those kinds of things.

Mary's account highlights the influence of heterosexual definitions of sex. Extreme vaginal dryness results in pain and sometimes bleeding during intercourse, but she and her husband do not take more time to stimulate lubrication or talk about how to make their sex more enjoyable. Also, Mary and her husband focus on intercourse in sex instead of intimate touching or oral sex. His question about when she will be "normal" implies that menopause has made Mary's sexual functioning abnormal because he defines sexual normality as intercourse rather than sexual pleasure for both of them. His assumptions and their lack of exploring other ways to have sex reproduce norms of heterosexuality, which focus on male-directed sex.

One woman initially describes vaginal dryness as problematic for intercourse but then describes problems with her prolapsed uterus. This account provides a further illustration of how internalizing cultural ideas about gender and heterosexuality may limit midlife women's sexual pleasure. Barbara, a 55-year-old Caucasian married for 32 years, first says that vaginal dryness after menopause affected her desire and enjoyment of sexual intercourse. However, over the past year, she and her husband do not engage in intercourse because her prolapsed uterus causes her pain during intercourse. Their sexual encounters now consist only of intimate touching. She uses a lubricant, which helps the dryness, but she does not like it because it is "yucky."

Barbara's doctor recommends a hysterectomy to alleviate the pain during intercourse but Barbara says: "I have been really putting off the decision because I don't really want to have a hysterectomy (because)…hysterectomies are really invasive." She explains that even though she is postmenopausal and cannot have children she does not want her uterus removed because "…it's just the whole idea of being a woman. I mean that's irrational. I know that." Barbara implies that she would feel less whole as a woman without her uterus but in the meantime says she feels "really, really guilty" because she cannot engage in intercourse with her husband.

Barbara's account illustrates the relationship between vaginal dryness after menopause, her conflicted feelings about femininity and her body, and her role as a female heterosexual partner. Her experiences with sex after menopause are affected by physical changes associated with menopause, vaginal dryness, as well as a prolapsed uterus. The meaning of those changes, however, for her sexual functioning is shaped by her sexual orientation and expectations in heterosexual relationships. Similar physical changes might not similarly affect a lesbian's sexual relations if she routinely reaches orgasms through intimate touching or oral sex. But because Barbara's definition of sex centers around intercourse, she does not feel satisfied with the type of sex she is having.

Similar to Jane and Mary, Barbara's account illustrates the influence of compulsory heterosexuality and gender in our society. Even though Barbara and her

husband reach orgasm through intimate touching, she implies that this form of sex is less fulfilling than intercourse, which is associated with "real" sex in heterosexual relationships (Connell, 1995; Schneider and Gould, 1987). Although Barbara's husband has never said anything about their lack of intercourse, Barbara says three different times that she "feels bad," perhaps because she cannot provide him with "real" heterosexual sex. Also, Barbara says that she and her husband do not sit down and talk about their feelings about their sexual issues; instead they make "passing comments" to one another.

From a psychological perspective, not talking about sex in heterosexual relationships is not unusual (Leiblum, 1990; Rubin, 1990), but could help couples understand what sexual activities please each other and help them change the ways they have sex (Leiblum, 1990). From a sociological perspective, this pattern of heterosexual women feeling reluctant to discuss their sexual preferences illustrates a consequence of women's socialization about heterosexuality and emphasized femininity (Connell, 1987; Lorber, 1993), which results in women deferring to men's preferences and following their leads during sex. Consequently, some women may not fully enjoy sex or learn how to exercise female sexual agency.

Lesbian Women: Flexible Definitions of Sex

The lesbians who describe unsatisfying sex also describe openly discussing their sexual desire and preferences with their partners, in contrast to the heterosexual women. As the lesbians discuss their sexual relationships, they do not focus on some

aspects of sex as more important than others. Therefore, the meaning of their menopausal changes for their relationships overall is less problematic compared to the heterosexual women in this study, in part, because of different definitions of sex. Their accounts illustrate female sexual agency as well.

For example, Marcia, a 48-year-old Mexican-American and partnered for 24 years, says that she and her partner have sex a lot less since menopause because her partner has vaginal dryness and menopause has exacerbated their different sex drives, which has always been an issue in their relationship. Marcia explains: "I'm kind of like one of those foreign sports car models and I run faster and hotter and she might be a Ford. It takes a little longer to warm up." Regarding orgasms, she says: "Where it would take her a long time to do one orgasm, I could go three and four times." Also, her partner's vaginal dryness makes her very sensitive to intimate touching; consequently she is "really tense about it (having sex)." Marcia describes a happy relationship overall, despite their difference in sex drives; she says: "There are moments when we can really be loving and I don't want to make it sound like we're not sexually into it. We really try to be…but we're just not to the point of orgasm all the time." Marcia says that they have two kinds of sex: "serious sex and laughing sex." Serious sex leads to orgasms and laughing sex involves sexual contact but "then something strikes us both funny and before we know it we're both falling down laughing and there's tears rolling out of our eyes and we can't stop."

Marcia's account illustrates the role of her relationship for shaping the meaning of her partner's menopausal changes and illustrates female sexual agency as well. Even though her partner's vaginal dryness and decreased libido affect their sex life (Marcia says it "can be a real drag"), Marcia says she "really (does) love her," and they continue to talk about how to make their sex life better. For example, they discuss different ways to have sex and because her partner is so sensitive to touch, sometimes she will stimulate herself during sex "so we're back on track." Unlike many of the heterosexual women in this study, Marcia and her partner do not discuss a certain aspect of lovemaking as real sex.

Therefore, Marcia's and her partner's flexible definition of sex, their open communication, and willingness to change the ways they have sex, lessen the effects of the menopausal changes for their sexual relationship. Furthermore, Marcia says that she masturbates sometimes, which her partner knows because they are very open with each other. Marcia's account provides an example of female sexual agency because she recognizes, discusses and acts on her sexual desire, both with herself and her partner.

Similarly, Kate, a 60-year-old Caucasian partnered for 17 years, says that she has vaginal dryness, which affects lubrication during sex. She says this difference is not a problem for her sexual relationship because "our sex is not like heterosexual sex." In other words, the dryness has not interfered with their intimate touching or her ability to have an orgasm. However, she and her partner do not have "orgasmic

sex" very often, every couple of months, which she attributes to their decreasing libidos. Kate says that their decreased libidos sometimes bother her, but she adds that she and her partner share a lot of non-orgasmic sexual contact: "(We) do a lot of touching and fondling. That's an everyday thing for us." Kate also says that she masturbates sometimes. Even though Kate is not completely happy about their sexual relationship, she characterizes their relationship as very happy and fulfilling overall. Like Marcia, Kate's account illustrates how relationship quality and flexible definitions of sex can minimize the difficulties that menopausal changes can have for women's sexual functioning.

Summary

The accounts in this section highlight the role of relationship quality and definitions of sex by sexual orientation for shaping the meaning of menopausal changes in women's sexual relationships. In particular, the heterosexual women discuss vaginal dryness as problematic for their sexual relationships because of the emphasis on intercourse in sex. Other issues such as ability to orgasm and a prolapsed uterus are problematic because of sexual socialization and past sexual experiences. Theoretically, these accounts illustrate how dominant social expectations about gender and heterosexuality result in women defining "real" sex as intercourse, following their husbands' leads, and feeling reluctant to openly discuss sexual issues with their husbands.

In contrast, the accounts from the lesbian women illustrate female sexual subjectivity and agency. These women describe flexible definitions of sex, discuss their sexual preferences with their partners, and describe taking pleasure in their bodies. They enjoy sexual contact alone and with their partners, and this contact does not always lead to orgasms. For example, Marcia distinguishes between "laughing sex" and "orgasmic sex." These accounts suggest that a broader definition of sexuality is needed in research to accurately reflect women's experiences and feelings about sex (Morokoff, 1988; Mansfield, Voda and Koch, 1995). Reducing sexuality to rates of intercourse or orgasms may overlook the range of ways women feel sexual pleasure.

No Sex With a Husband or Partner

Thirteen women, eight heterosexual and five lesbian, say that they are not currently having sex with anyone. The reasons include not in a relationship, health issues, relationship issues, and past sexual traumas. Some women also describe vaginal dryness, and libido and orgasm changes, but they emphasize these other social factors to explain why they are not having sex.

Not in a Current Relationship; Poor Quality of Past Relationships

Seven women, five heterosexual and two lesbian, explain that they are not currently having sex with anyone because they are not in a relationship. All of the heterosexual women are divorced. Many of the heterosexual women, and one

lesbian, were married when they first became postmenopausal and they discuss the menopausal changes and problems in their relationships during this time. For example, one woman experienced vaginal dryness but estrogen cream helped alleviate the dryness. Two women noticed libido changes, one woman's increased and the other's decreased. However, the context of these women's relationships shapes the meaning of these menopausal changes for their sex lives. In other words, these women experienced difficulties in their sexual relationships and eventually stopped having sex not because of menopausal changes, but because of the poor quality of their relationships. Some of these accounts provide additional examples of how dominant ideas about menopause and heterosexuality can limit women's sexual agency.

For example, Peggy, a 57-year-old African American who divorced three years ago, says that for several years in her late 40s she was in the menopause transition. As discussed in Chapter Three, she expected her sexual desire to decrease after menopause, but contrary to her expectations, her libido increased. She tried to act on her increased desire, but her husband rejected her. This account illustrates how poor relationship quality and dominant ideas about menopause, gender and heterosexuality, can limit women's sexual pleasure and sexual agency.

First Peggy describes how perimenopause increased her libido:

> I thought at one time, "Oh I probably won't have sex any more. I probably won't even like it." But that was not so. I became, I don't know if I can say this or not, I was really horny! That's how it (perimenopause) affected me!

> ….(I thought), "This is GREAT. Jump on those bones! Come on!" I could hardly wait.

Peggy also says that, during perimenopause, her orgasms came easily and were intense. She says: "I didn't know whether it was because I thought that as I was approaching menopause, I would not enjoy sex more so I was gonna go out of my way to make sure I did. So maybe I was putting more of myself into it." Peggy explains that she does not know whether to attribute her sexual interest and enjoyment to the hormonal changes of perimenopause or to her motivation to resist cultural expectations that she would not enjoy sex as she approached menopause.

But after the first two years of having erratic periods, Peggy's husband experienced erectile dysfunction after heart surgery. She tried to talk to him about his dysfunction, but he refused. They stopped having sex for about five or sex years, until he filed for divorce. Peggy stopped menstruating during this time. She reflects on her difficulties talking to her husband:

> But I got to realize that talking about manhood is just very taboo, I guess. Even though you've been married to this person all this many years and it should be just a very natural part of your concern and conversation and he didn't want to share any of that and he just became even more withdrawn.

Peggy's account contains an example of a woman openly discussing her desire and acting on her desire until her husband continually rejects her. Her husband's reluctance to discuss his difficulties with erections and Peggy's observation that "…talking about manhood is just very taboo" reflects a consequence of masculinity and heterosexuality. His masculine identity may be wrapped up with

his sexual identity, which is defined by performance not emotions (Connell, 1995). Discussing his problems with erections may be too embarrassing, so he refuses to talk to Peggy, which limits her attempts to act on her sexual desire.

Selena, a 60-year-old Caucasian lesbian, was married to her second husband during perimenopause and when she first became postmenopausal. Her account illustrates how the poor quality of her past heterosexual relationships and the lack of a current relationship shape the meaning of her changed libido during perimenopause. As discussed in Chapter Three, during perimenopause, Selena was married to an abusive man and also realized she is a lesbian. Selena says that when she became menopausal, she noticed that her interest in sex decreased but explains that it was because of her relationship; she says: "Because he was a very bad lover. Yea. Totally fixated on it (intercourse) and no skill at all." Yet, Selena followed his lead and did not discuss different ways to have sex.

When she first became involved with a woman, however, she says that "…the drive came well to active levels again." She compares the orgasms she had with her lesbian lover to those with her first husband, to whom she was married in her late 20s to her mid-40s. She says her first husband "was very, very good at foreplay, which is basically what lesbian sex is." Also, she says that the quantity and quality of her orgasms were similar in her first lesbian relationship to her first marriage, more than 15 years earlier. Therefore, Selena emphasizes the quality of her relationships, not her age or her menopausal status, to explain the quality of her sexual functioning.

She says that she feels certain she would be sexually active if she was involved with someone.

Unlike most of the women in this study, Sally, a 56-year-old Swedish-American lesbian, describes her past sexual relationships and her sexuality in general in detail with frankness and confidence. This account illustrates sexual subjectivity and agency. Her account also highlights the importance of documenting how women feel about their sexual functioning not only after menopause, but also throughout their lives.

For example, early in the interview, Sally describes her difficulty adjusting to American schools as a young girl because she did not know English. She says that she started masturbating when she was 12 to relieve this stress:

> You know, I know about my body, I would say since 12. And I never felt masturbating was negative or anything like that. I knew you did it privately….I tell you I wouldn't have gotten through school unless I masturbated.
>
> (JW: Really?)
>
> Because it took a lot of tension. I really think that orgasms—that people that are frustrated, what they need is a good orgasm!

Sally describes herself before menopause as a "very good love maker" and:

> Very sexual. I mean I could have three or four orgasms at a time and I really needed orgasms….To make me stimulated it always used to be like when spring came and you hear the birds and you hear even the wind blowing on my face and smelling the nice air. And nature and stuff could just turn me on like that.

Since menopause, Sally says that she does not have vaginal dryness, but her desire and orgasm quality have decreased. She speculates that, initially, these changes were due to her deteriorating relationship and to menopausal changes. Shortly after her relationship ended, she had an affair and said that her desire returned, but her orgasms were not "very nice ones," because they came fast and were short. Recently, she says: "Now I tried playing around a little bit last weekend and I had like three little orgasms. But they felt a little better. But now I'm fine. I don't need them for a while. But it used to be that I liked to have an orgasm almost every day."

Sally says that now she "would be happy to have one orgasm a month and that would be okay for me. My body does not need more than that." Arguably the hormonal changes of menopause have changed Sally's orgasm intensity. But, because Sally views orgasms as a "physical thing that everybody needs to have" and not just as a part of sexual relationships, she views the changes in her orgasm intensity as normal for her body. This account highlights why researchers need documentation of women's views about their sexuality from their perspectives. Not only does sex drive and sexual functioning vary from woman-to-woman, but also Sally's account suggests that some women's sexual functioning may significantly change over the course of their lives. Documenting the rate of changes overlooks the meaning of these changes for women's sexual pleasure and well-being. Therefore, researchers cannot know whether to characterize women's changed sexual activity

level and orgasm rates as "dysfunction" or normal unless they know how women feel about these changes (Mansfield, Voda and Koch, 1995).

Most of the accounts in this section highlight the role of relationship quality and status rather than menopausal changes for women's sexual functioning. Currently, none of these women are sexually active with a partner because they are not in a relationship. When these women reflect on their past sexual relationships, they emphasize their problematic relationships to explain why sex was not satisfying, instead of vaginal dryness or libido changes. Some of these accounts also provide examples of how social expectations about menopause and heterosexuality can limit women's sexual agency and pleasure. In contrast, Sally's account provides a strong example of female sexual agency. Her account also suggests that researchers who want to understand women's changes in sexual functioning after menopause need to understand how women view the meaning of those changes for their sexual functioning and well-being overall.

Health Issues

Four women, one lesbian and three heterosexual, say that they no longer have sex because of health issues. The heterosexual women explain that their sex lives ended because their husbands have prostate problems. Theoretically, the heterosexual women's accounts provide further illustrations of how dominant ideas about gender and heterosexuality become internalized, recreated and bolstered through interactions.

The lesbian woman explains that both she and her partner take Prozac, an antidepressant, which has affected their libidos. This account illustrates the importance of documenting women's perspectives about sex and intimacy because even though this woman does not have sex with her partner, she enjoys a very affectionate and emotionally intimate relationship.

Janet, a 52-year-old Caucasian partnered for 19 years, says that she stopped having sex with her partner before she experienced menopause, about 11 years ago:

> (JW: How about your sexual relationship?)
>
> Nonexistent (laughs). Some of which I attribute to Prozac. Which actually we both take. Although she does not divulge that to people generally. But I think that has an effect on libido and so we do a lot of touching and hugging and kissing, but we haven't had sex in years. So I can't say that we've missed it.

Janet's sexual history may partially explain why she does not miss sex with her partner. Earlier in the interview, Janet explains that, for most of her life, she "was sort of avidly heterosexual." She says that she is "more of a situational lesbian than a constitutional lesbian." Janet could not find an emotionally sustaining relationship with a man, however, so when she met her partner:

> …we went through several years of my approach avoidance in terms of is this who I really want to settle down with. And finally I came to the conclusion that regardless of whatever other pressures there might be in terms of the relationship, that this was the relationship that I was going to make a commitment to.

For Janet, menopause did not affect her sexual relationship at all, because it ended about nine years before her last period. Janet's account about her avid

heterosexual past and her current affectionate but not sexual relationship suggests that perhaps she did not enjoy lesbian sex. But, perhaps she did not enjoy heterosexual sex either. Unlike the rest of the interview, Janet stopped giving detailed responses during the sexuality questions, so my interpretation of her lack of a sexual relationship is limited by her brief answers. In her description of their relationship overall, Janet emphasizes feeling secure and comfortable. Janet says that they comment to each other several times a day about how lucky they feel. When we discussed her sexual relationship, she laughed and insisted that she does not miss it.

Regardless of whether Janet did or did not ever enjoy sex, her account illustrates the importance of documenting women's perspectives and views about sex and intimacy. Although she does not have sex anymore, her account suggests that her relationship is emotionally fulfilling and very affectionate. In other words, her relationship is physically and emotionally intimate, but not sexual. This account suggests that understanding midlife women's sexual well-being requires researchers to broaden their definition of sex and intimacy beyond specific sexual practices.

As the heterosexual women discuss their husbands' prostrate problems, they also discuss their past sexual relationships. Similar themes emerge in these accounts regarding difficulties talking to their husbands about sex as well descriptions about unfulfilling sex. Theoretically, these accounts provide further examples of how heterosexual norms and gendered expectations limit women's sexual pleasure.

For example, Sarah, a 58-year-old Caucasian married for 36 years, first noticed vaginal dryness about the same time her husband noticed difficulties maintaining erections. He tried Viagra, which did not work. Sarah says that she does not miss intercourse because although she did "enjoy it when it was done right," she says: "I always wish it was (done right) more often." Sarah explains that she had orgasms only through foreplay and regarding intercourse, she says: "I never felt much inside." During sex they often immediately began intercourse and "sometimes it went on forever…do that manly thing." She says that her husband was not very good at sex because he started intercourse too quickly, therefore, she does not miss it. However, Sarah never talked to her husband about her preferences during sex. She says that because she controlled most aspects of the house and the children, she thinks sex "was his one spot there was control." Therefore, she let him take control over how their lovemaking sessions would unfold, even though she often felt unsatisfied.

Similarly, Chiyo, a 64-year-old Japanese-American married for 26 years, stopped having sex about three years ago because of her husband's prostate problems, which concerns her husband. Chiyo reassures him that she enjoys their affection, hugging, holding hands, and kissing. Chiyo implies, however, that she never fully enjoyed sexual intercourse; she says: "I'm so happy, I had enough of it (laughs)." She reveals that she is uncertain whether she ever had an orgasm, but she led her husband to believe that she enjoyed sexual intercourse more than she did. She says: "I wanted to make him happy. Maybe I was faking (laughs). I don't know, I wanted

him to feel like a real hero!" Chiyo never told her husband she is uncertain whether she experienced an orgasm and never told him her preferences during sex.

Finally, Carol, a 71-year-old Caucasian married for 49 years, has not had sexual intercourse with her husband for the last 10 years because of his prostate surgery. As we discuss their sexual relationship before the surgery, she tells me that she did have vaginal dryness but soon started HRT, which alleviated it. When I ask her about orgasms, she says: "Well, you know, women don't always have orgasms, mostly always men do. The men usually always have the orgasms. I didn't always have orgasms, but, yes, I did, and I enjoyed that and so on." Carol continues by saying that she and her husband sometimes talked about the fact she did not have an orgasm and she would tell him: "I don't have to." But she says that she never faked having orgasms either.

These accounts illustrate how dominant cultural ideas about gender and heterosexuality become internalized, recreated and bolstered through interactions. For example, both Sarah and Chiyo associated long periods of intercourse with masculinity and heterosexuality; Sarah describes it as "do that manly thing" and Chiyo wanted her husband to feel "like a hero." Also, both women imply that they followed their husbands' leads during sex and allowed intercourse to last a long time, even though they did not always enjoy it.

Chiyo's experiences may also be influenced by her Japanese socialization. When I ask her why she does not talk to her husband about sex, she says: "…being

Japanese, I'm so reluctant to talk." Chiyo explains that Japan is not a "couple society," and couples her age do not hug and kiss in public. Chiyo and her husband never talked about sex until he had prostate problems, and only then they discussed it because he asked her about it. She also says that she has never talked to her doctors, friends or her sister, who is her best friend, about sexuality issues because sex is not a topic people her age discuss in Japan. Therefore, Chiyo's tendency to follow her husband's lead, not talk to him about her preferences about sex, and to pretend to enjoy long periods of intercourse, may be influenced by her socialization as a Japanese woman as well as her internalization of American heterosexual norms.

These accounts illustrate cultural assumptions about female sexuality and orgasms in heterosexual relationships. By assuming that women's orgasms are not as necessary as men's, these women confirm dominant cultural ideas about gender and heterosexuality, which define women as objects of male desire. Furthermore, one consequence of bolstering norms of gender and heterosexuality through interactions is that these heterosexual women do not always enjoy intercourse or act on their desire. Sarah only reached orgasms through touching, not intercourse, Chiyo is uncertain whether she ever had an orgasm, and Carol says that men always have orgasms, not women. In part, because of these women's assumptions about the relative importance of female orgasms, and because they followed their husbands' lead and did not discuss their preferences during sex, they did not often have satisfying sexual experiences.

Relationship Issues

One woman, Brenda, a 58-year-old Caucasian lesbian partnered for eight years, says that she stopped having sex several years ago because of lack of interest, which she attributes to expectations about aging. Brenda and her partner are also in couple counseling, and she explains that their lack of lovemaking has not come up in the sessions; she says:

> Ann and I don't have sexual relations and haven't for several years. And it's like it's a mutual thing and it's agreeable and it's not an issue….It's just as nice without it, oh well, that's what I hear. Older people, that's what happens. So it's just that we sort of accept it as not a problem. I mean it has never come up in our couples counseling at all. So, it's not something that we feel a need to fix or to do anything about.

However, as the interview continues, Brenda reveals a conflicted account of their lack of lovemaking and her sexual interest. First, she describes her unhappy and unsatisfying marriage. She recalls the last time she made love with her husband; she says: "I ended up crying and that's when I decided I can't do this any longer." When she became involved with women, she says: "When I first became a lesbian it was, the sex part, very nice, you know. It was a new feeling for me because when I was married it was not something that I really enjoyed." She then describes her relationship with Ann as very sexually compatible at first and says "that was an important part of the attraction."

Brenda reveals that she continues to feel sexual desire and she masturbates sometimes when Ann is not in the house. She explains some of the problems that she

and Ann are experiencing and describes her attraction to another woman. Brenda speculates that if she started a new relationship that sex "would be part of it."

Brenda's conflicted account about her expectations about aging and sex, her enjoyment of lesbian sex, her continued interest in sex and masturbation, her relationship problems, and her attraction to another woman, all suggest that her current decreased interest in sex has less to do with expectations about aging, or decreased libido due to menopause, than the quality of her relationship.

Past Sexual Abuse

One woman, Andrea, a 49-year old African-American lesbian partnered for over two years, has vaginal dryness and reduced libido since menopause, but explains that she is not having sex with her partner because of emotional scars from past sexual abuse. When she was sexually active, she noticed discomfort and pain with digital and dildo penetration because of vaginal dryness. But she does not engage in any sexual contact, and has not for almost two years because she says she "was not responding" during sex.

Although Andrea says that vaginal dryness is uncomfortable, her reason for not having sex centers on her past. She is a victim of incest as a child and also suffered from sexual abuse from men outside of her family; she says: "I actually believed that if he loved me (that meant)…he was having hard sex with me. That was the abusive sex when they're pounding you." Andrea was pregnant at 11 and had an abortion; she became pregnant again in her teens and had more abortions. Recently,

she has lost a number of family members including her mother. Andrea says that she is trying to work through her past and her current grief so that she can be intimate with her partner.

Her account suggests that even though she has vaginal dryness and decreased libido, past sexual abuse and current family deaths explain her lack of interest in sex and lack of sexual activity. Andrea explains that she is currently learning how to recognize sexual desire and how to act in her body instead of being acted on; she says: "I find myself redefining my sexuality and my womanness (as I come) into this stage."

Summary

The accounts in this section suggest that these heterosexual and lesbian women are not having sex because of relationship status, health issues, relationship problems or past sexual abuse. Many of these women also experienced physiological changes relevant to sexual functioning during and after the menopausal transition. They emphasize, however, that social factors, not menopausal changes, explain their current lack of sexual activity.

Theoretically, some accounts in this section illustrate how cultural ideas about gender and heterosexuality affect women's sexual relationships and may limit their sexual agency. For example, one heterosexual woman recounts her difficulties talking to her husband about his erectile problems; his reluctance to discuss this issue suggests that his masculine identity is tightly woven with his heterosexuality. Some

heterosexual women follow men's leads during intercourse even though it is unsatisfying and lasts too long, which confirms dominant cultural expectations about femininity. These accounts illustrate how some women internalize social expectations about gender and heterosexuality and reproduce them through their sexual interactions. One consequence of this process if that they normalize the definition of sex as intercourse, which is a social construction, and do not act on their desire and in their bodies.

Conclusion

This chapter highlights the importance of the social meaning of menopause and midlife sex. The findings illustrate the importance of not reducing the menopausal changes relevant for women's sexual functioning to a biological event. The physiological changes in themselves are not necessarily problematic for women's sexual functioning and sexual pleasure. Rather, the findings suggest that vaginal dryness and libido and orgasm changes have different meanings for women's sexual functioning and pleasure depending on the status and quality of their relationships, sexual orientation and definitions of sex, health issues, and in one case, sexual history. Furthermore, how women view these changes and their sexual functioning is important information to fully understand menopausal women's sexuality.

More heterosexual women describe vaginal dryness as problematic because of the focus on intercourse in heterosexual relationships and the difficulties many heterosexual women have openly discussing sexual issues with their husbands. Also,

most heterosexual women with vaginal dryness say that their sexual repertoire has not changed to allow more time for lubrication. Finally, many accounts in this study suggest that the distinction between foreplay and intercourse may deny women opportunities to climax.

Conversely, most of the lesbian women's accounts in this study suggest that menopausal changes do not significantly change the quality of their sexual functioning. Many lesbians openly discuss their sexual desire and preferences, change the ways they have sex and have flexible definitions of sex. For example, none of the lesbians said that any particular aspect of their lovemaking is most important.

Theoretically, these findings suggest that cultural expectations about gender and heterosexuality become reproduced through social interactions and, in some cases, may limit women's sexual agency. Many women's accounts illustrate consequences of social expectations about heterosexuality, which result in women following men's lead during sex rather than taking the lead and communicating about what they find pleasurable. Some women may fake orgasms because they recognize the importance of sexual performance for men's identities, which normalizes dominant cultural ideas about gender and sexuality. In other words, by following men's leads and faking orgasms, some women are confirming the dominant cultural story about heterosexual sex, which focuses on male-defined sex and women as objects of male pleasure. In contrast, some heterosexual and many lesbian accounts

illustrate female sexual agency (Martin, 1996). These women describe actively discussing and acting on their sexual desire and finding pleasure in their bodies both with their partners and by themselves.

Some women describe non-orgasmic sensual touching as well. In fact, out of the 30 women I interviewed, 25 gave me specific examples of moments of intimacy with their current husband or partner or from past relationships. The women's examples are similar in their descriptions of moments of feeling close, but some focus on physical contact while others describe emotional closeness. The accounts on women's descriptions of sex and intimacy suggest that most women in this study view intimacy more broadly than sex. These accounts provide insight into ways that midlife sexuality researchers could conceptualize sexuality and intimacy from women's perspectives (Morokoff, 1988; Mansfield, Voda and Koch, 1995). Defining sexuality through intercourse and orgasm rates overlooks the many ways midlife women feel sensual and close to their husbands and partners. Future researchers could ask questions about intimacy and non-orgasmic sensual touching to gain a fuller understanding of how women define sexuality and feel about their midlife sexual functioning and well-being.

Chapter 5

Politics of Hormone Replacement Therapy

For those women who seek medical care, the rite of passage of menopause is often accompanied by a doctor's recommendation to take HRT for the rest of their lives to help prevent osteoporosis and heart disease. Premarin, the most popular form of HRT, is the most prescribed drug in America (Love and Lindsay, 1997), despite the fact that the benefits and risks of HRT are unclear. The medical knowledge about the benefits of HRT for women's cardiovascular systems and the risks for cancer has shifted in the past year. Consequently, doctors who promote taking HRT for long-term health benefits are basing these claims on medical knowledge that is increasingly in flux.

This chapter provides background information for the next chapter, which analyzes women's experiences with doctors and hormone replacement therapy. The information in this chapter is important to fully understand how the medical advice women receive about HRT is based on inconclusive and changing medical evidence about the benefits and risks of HRT. Despite this inconclusive medical evidence, many doctors present the benefits and risks as definitive, which arguably influences women's decisions whether to take HRT and how they view their health.

Historical Overview and the Politics of HRT

The changing historical and medical definitions of menopause demonstrate how cultural views about women and menopause have shifted over the past 100 years. Belgrave (1993:191) summarizes these shifting definitions and describes how menopause first became defined as a medical condition:

> During the Victorian era, menopause was seen as a sign of "sin and decay." With the Freudian influence of the early twentieth century, this conception changed and menopause came to be seen as a neurosis. The advent of synthetic hormones in the 1960s brought a dramatic change in the medical view of menopause. The pharmaceutical industry had developed a readily available treatment in need of a disease. The medical community found that disease in menopause, which became defined as a deficiency disease, the treatment of which was estrogen replacement therapy.

Medical researchers first developed synthetic estrogens in the 1930s and 1940s, but estrogen was not widely promoted by doctors for treating the so-called symptoms of menopause until the 1960s (McCrea, 1983).

Arguably, Dr. Robert A. Wilson was the most aggressive and sexist promoter of estrogen replacement therapy (ERT). He compared menopause as an estrogen deficiency disease to other deficiency diseases, such as diabetes and thyroid dysfunction (McCrea, 1983). His 1966 book, *Feminine Forever,* popularized the idea of menopause as a disease and he advocated that women take ERT to prevent aging and to maintain their youthful attractiveness. He warned that 85 percent of menopausal women would suffer serious symptoms and that "no woman can be sure of escaping the horror of this living decay" (Wilson cited in Ferguson and Parry, 1998). Even though Wilson's claims for eternal youth and his views about

menopausal women may seem extreme, at the time, his book was popular and widely available (Coney, 1991).

During the 1960s and 1970s, many practicing physicians prescribed estrogen to their patients, which perpetuated the definition of menopause as a health problem. According to the U.S. Bureau of the Census, sales of estrogen replacement quadrupled between 1963 and 1973 (Hoover et al., 1975, cited in McCrea, 1983). In 1975, estrogen replacement therapy ranked as the fifth most frequently prescribed drug in the United States (Hoover et al., 1975, cited in McCrea, 1983).

In the late 1970s and early 1980s, physicians dramatically reduced the number of ERT prescriptions, however, because medical studies suggested a link between ERT and endometrial cancer (McCrea, 1983). In 1975, the *New England Journal of Medicine* published the results of two epidemiological studies, which found a link between postmenopausal estrogen therapy and endometrial cancer. By 1980, nine more studies concluded that women who took ERT increased their chances of developing endometrial cancer four to 20 times more than women who never took ERT (MacPherson, 1990; McCrea, 1983).

While prescriptions for ERT declined, medical researchers, funded by pharmaceutical companies, developed a new pill called hormone replacement therapy. This pill combines estrogen with progestin, a synthetic progesterone. Progestin sloughs off the uterine build-up caused by estrogen and medical research suggested that this new form of hormone therapy *protects* women from uterine

cancer. Starting in the 1980s, doctors widely prescribed HRT to postmenopausal women with uteruses and by the mid 1990s, Premarin the most popular form of HRT, became the most prescribed drug in America (Love and Lindsay, 1997).

Unlike the Wilsonian promotion of ERT in the 1960s and 1970s as a femininity pill, doctors promoted HRT as an important way for women to maintain their long-term health. Starting in the late 1980s and until recently, doctors promoted HRT not only to help alleviate hot flashes and vaginal dryness, but also to prevent age-related diseases, such as osteoporosis and heart disease.

Even though practicing doctors advocate the benefits of HRT for women's long-term health, medical researchers disagree about the risks and benefits of HRT (Colditz, 1996; Coney, 1991; Love and Lindsay, 1997; Sullivan and Fowlkes, 1996). An exhaustive review of medical studies on the risks and benefits of HRT are beyond the scope of this dissertation; however, in the next section, I will explain the primary benefits, alternatives to, and risks of HRT. (For popular books on the general benefits and risks of HRT, see: *The Complete Book of Menopause: Every Woman's Guide to Good Health,* by Carol Landau, Ph.D., Michele G. Cyr, M.D., and Anne W. Moulton, M.D., 1994; for detailed biological information on HRT, breast cancer risk, and alternatives to HRT, see: *Dr. Susan Love's Hormone Book*, by Susan Love, M.D. with Karen Lindsey, 1997; for information on osteoporosis including the benefits of HRT for bone health, see: *Strong Women, Strong Bones: Everything You Need to*

Know to Prevent, Treat, and Beat Osteoporosis, by Miriam E. Nelson, Ph.D. with Sarah Wernick, Ph.D., 2000).

HRT: Benefits, Alternatives, and Risks

Benefits of and Alternatives to HRT

The current state of medical knowledge strongly suggests that HRT is effective for reducing or eliminating hot flashes and vaginal dryness and can help prevent osteoporosis as well. Until recently, doctors believed HRT benefited women's cardiovascular systems, but that assumption has been called into question by early findings from a clinical trial. Therefore, I will discuss HRT and cardiovascular health separately.

HRT is administered in many different combinations of estrogen and progesterone. Premarin, the most common form of estrogen, is made from pregnant mares' urine. About 50,000 mares are impregnated each year and for seven months of the eleven-month pregnancy, they are given minimal water to drink to increase the concentration of their urine (Love and Lindsay, 1997). (The animal rights movement is fighting this use of mares (Love and Lindsay, 1997)). Most of the medical studies conducted on the effectiveness of estrogen for alleviating changes associated with menopause and preventing other diseases are based on Premarin because the manufacturer of Premarin, Wyeth-Ayerst, dispenses it free to researchers (Love and Lindsay, 1997).

Other formulations of estrogen are made from plants or synthesized in laboratories using chemical formulations (Love and Lindsay, 1997). As discussed, a synthetic progesterone is added to estrogen to help prevent endometrial build-up. Synthetic progesterone, or progestin, is processed differently than the natural progesterone found in a woman's body, which her body stops producing altogether after menopause (Love and Lindsay, 1997). Natural progesterone, produced from plants and most like the progesterone women's bodies produce, is available but rarely used because it cannot be patented (Love and Lindsay, 1997). Therefore, most women take a synthetic progesterone typically in pill form. In the United States, HRT can be taken in a pill, worn as a patch or administered through a vaginal cream. In other countries, HRT can also be administered through a gel applied to the skin or a transdermal implant, similar to Norplant (Love and Lindsay, 1997).

HRT is very effective for reducing or eliminating hot flashes (Landau et al., 1994; Love and Lindsay, 1997; Perry and O'Hanlan, 1992; Utian and Jacobowitz, 1990). For women who lose sleep from uncomfortable night sweats, HRT can bring welcome relief within a few days of starting it. Hot flashes occur for "an indefinite but limited period of time after menopause" (Landau et al., 1994:144). Women who wish to take HRT to alleviate hot flashes and night sweats can take it for six months to a year and then gradually decrease the amount of estrogen to test whether hot flashes will recur (Landau et al., 1994; Love and Lindsay, 1997).

Alternatives to HRT for alleviating hot flashes include lifestyle changes, supplements and acupuncture. For lifestyle changes, women can dress in layers, avoid caffeine and alcohol, exercise, meditate, and reduce stress. Dietary soy protein is the only supplement that recently has been studied in a randomized controlled study, in Australia, and proven to help reduce hot flashes. Other supplements that may help, but have not been studied in clinical trials, include vitamin E and possibly B vitamins (Love and Lindsay, 1997).

The only herb studied in randomized controlled studies is black cohosh; Germany has studied this herb extensively. A capsule form of black cohosh is the most popular alternative to HRT in Germany, but because the long-term effects are not known, a governmental regulatory group limits its use to six months (Love and Lindsay, 1997). In one study, black cohosh was found to be as effective in reducing hot flashes as Premarin. Other herbs that may help with hot flashes but have not been studied include garden sage, motherwort, and dong quai. These herbs have an estrogenic effect in varying degrees and should probably be avoided by women who are at risk for breast cancer (Love and Lindsay, 1997).

HRT can help with vaginal dryness, but not in all cases (Love and Lindsay, 1997). Women may need additional lubricants to help restore moisture. Women can use estrogen creams inside the vagina, which help restore lubrication. Because the estrogen in these creams is absorbed in the bloodstream, women who do not want to absorb estrogen systemically and want to avoid dangerous side effects should use a

very low dose, about 1/10 to 1/30 of what the manufacturers' recommend (Love and Lindsay, 1997). A new low-dose estrogen ring, similar to a diaphragm, is recently available in the United States (although it been used for in Europe for some time). This ring releases small amounts of estrogen over time (Love and Lindsay, 1997).

Non-estrogen options include other vaginal lubricants used at the time of penetration such as K-Y Jelly and Astroglide. Replens can be used on a regular basis to eliminate dryness; it helps the vagina absorb water. Finally, women can open vitamin E capsules and apply the oil inside their vaginas (Love and Lindsay, 1997). Simple lifestyle changes include drinking a lot of water and maintaining regular sexual activity, either alone or with a partner. Orgasms help "exercise" the vagina, increase blood flow and may stimulate estrogen production in the adrenal glands, which keeps the vagina lubricated (Perry and O'Hanlan, 1992).

Estrogen also helps a woman's body absorb calcium, which can help prevent osteoporosis, a disease that can lead to bone fractures. Women's bone density generally peaks in the early to mid-30s and then bone mass loss gradually occurs until menopause. Immediately after menopause, bone loss accelerates for three to seven years and then slows down (Perry and O'Hanlan, 1992).

In some women, gradual bone loss leads to osteoporosis, which literally means "porous bones." Estrogen does not stimulate new bone growth, it prevents bones from thinning and weakening further by increasing a woman's ability to absorb calcium and to conserve calcium in their bones (Landau et al., 1994). Once a woman

stops taking estrogen, her bone loss will resume at the same pace as it would have after menopause (Landau et al., 1994). Therefore, to gain maximum bone protection, a woman should take HRT soon after menopause and for the rest of her life.

Osteoporosis can be a serious condition and, in rare cases, can lead to death. Every year in the United States, osteoporosis causes an estimated 1.3 million fractures in people over 45 (Perry and O'Hanlan, 1992). However, low-bone density in itself may not be problematic, but rather, whether women fall. The average age for a hip fracture, the most problematic type of fracture for women's health, is 80 (Love and Lindsay, 1997). Furthermore, some researchers question the definition of osteoporosis and the standard for "normal bone density," which is based on standard deviations from an average white, 35-year-old female body (Love and Lindsay, 1997). For example, Asian women have less bone density than Caucasians, but suffer from far fewer fractures.

Not all postmenopausal women develop osteoporosis. The risk factors for osteoporosis include fair complexion, small-bone structure, history of eating disorders, low weight, low-calcium diets, lack of exercise, family history of osteoporosis and smoking (Perry and O'Hanlan, 1992). Until recently, doctors did not detect osteoporosis until a woman broke a bone. Now, advanced bone-measuring technologies can assess bone strength and alert women about thinning bone mass before they break any bones. Also, the medical establishment knows more about

what lifestyle choices can prevent osteoporosis and have developed a number of drug therapies to preserve bone mass (Harvard Women's Health Watch, 2001).

Calcium is essential for maintaining bone strength. The human body cannot store calcium, therefore consuming adequate amounts of calcium daily, between 1,000-1,5000 milligrams, is very important for bone health. Also, the body needs Vitamin D, between 400-1,000 milligrams, to properly metabolize calcium (Harvard Women's Health Watch, June 2001). Regular weight-bearing exercise is also important for bone health because exercise stimulates bone cell activity, which increases bone strength. Finally, eating fruits and vegetables high in potassium and magnesium helps maintain a balance of acidity in the blood; if blood is too acidic, the body neutralizes it by taking calcium from the bones. Some research also suggests that a high protein diet can raise acid levels in the blood; therefore, following federal guidelines for protein intake may also help bone health (Harvard Women's Health Watch, March 2001).

For those women at risk of developing osteoporosis or who have it, they can choose from several medications that help stop bone loss or improve bone strength. As stated, HRT helps prevent further thinning of the bones by aiding the body's absorption of calcium and preserving calcium in the bone. HRT is particularly useful for preventing osteoporosis because it maintains bone density at all sites in the body. However, HRT increases the risk for breast cancer when used for more than five years. Other side effects include breakthrough bleeding, breast tenderness, headaches

and possible weight gain (Harvard Women's Health Watch, March 2001; Landau et al., 1994; Perry and O'Hanlan, 1992; Utian and Jacobowitz, 1990).

If women cannot take HRT because of cancer risk or do not want to take it because of other side effects, several other medications are also available. Women can opt to take a selective estrogen receptor modulator (SERMs) commonly known as Evista. This drug is a form of estrogen but is processed by the body locally, not systemically. SERMs are like keys that can only unlock certain estrogen receptor cells in the body. This drug helps prevent and treat osteoporosis by increasing bone density at the spine, hip and neck. Rarely, this drug can cause blood clots. More common side effects are hot flashes and leg cramps (Harvard Women's Health Watch, March 2001).

Bisphosphonates, commonly known as Fosamax or Actonel, help prevent and treat osteoporosis by increasing bone density at the spine and the hip. Some women find these medications difficult to digest and they can cause nausea, heartburn, or irritation of the esophagus or stomach if taken with food 30 minutes after taking the medication (Harvard Women's Health Watch, March 2001).

A final medication option is Calcitonin, commonly known as Miacalcin or Calcimar. This drug is used only for treatment of osteoporosis; it decreases bone loss at the spine and reduces bone pain from osteoporosis-related fractures. Calcitonin can be administered through injection or a nasal spray. The injected form can cause allergic reactions which results in flushing of the face and hands, nausea and a skin

rash. The nasal spray can lead to a runny nose or nosebleeds (Harvard Women's Health Watch, March 2001).

In summary, the conclusive benefits of HRT include eliminating or reducing hot flashes and vaginal dryness and preventing osteoporosis. As discussed, women can choose alternatives to HRT for all of these conditions if they cannot or do not want to take HRT.

HRT and Cardiovascular Disease: Helpful or Harmful?

Another benefit associated with long-term HRT is reducing the risk of cardiovascular disease, but this benefit is inconclusive. For over 20 years, doctors advocated long-term use of HRT to maintain heart health, but recent medical evidence suggests that medical advice is not well supported. This section discusses the assumed benefits of HRT for women's cardiovascular systems and recent clinical trials that suggest HRT may actually increase cardiovascular events.

The FDA never approved estrogen as an effective drug to prevent heart disease. Yet, for the past 20 years or so, doctors encouraged women to use it for that purpose, based on biological and observational studies. Medical researchers observed that heart attacks are less likely to occur in premenopausal women compared to men the same age. Women's risk for heart attacks rises significantly after menopause and approaches, but never reaches the same rates as men (Love and Lindsay, 1997). Also, when younger women undergo surgical menopause, their risk for heart disease rises rapidly if they do not take estrogen replacement. Therefore, doctors assumed

that estrogen must play a role in protecting women from heart disease (Harvard Women's Health Watch, June 2000).

Observational studies repeatedly suggested that women who take estrogen or hormone replacement therapy are at lower risk for cardiovascular disease (Harvard Women's Health Watch, June 2000). Medical research suggested that estrogen favorably affects cholesterol levels in the blood by raising the "good" cholesterol levels (high density lipoprotein) while lowering the "bad" cholesterol levels (low density lipoproteins). Too much "bad" cholesterol can block arteries leading to heart attacks. This favorable balance of "good" and "bad" cholesterol levels helps reduce the risk of heart disease and stroke by maintaining healthy blood flow through the arteries (Perry and O'Hanlan, 1992).

Doctors' assumptions about the protective role of estrogen for women's hearts were based on the best medical evidence available at the time, but none of the medical studies were based on clinical trials. One problem with observational studies, such as the Nurses' Health Study, which is a longitudinal study of 122,000 nurses and a primary source of knowledge for the benefits of HRT, is that scientists do not know whether these participants' favorable health statuses are due to HRT or other lifestyle factors. For example, risk factors for cardiovascular disease include family history of heart disease, smoking, obesity, lack of exercise, high cholesterol and high blood pressure (Colditz, 1996; Sullivan and Fowlkes, 1996). Perhaps the participants in the Nurses' Health Study lead healthier lives than people in the general

population. Also, these women may have better access to medical knowledge and health care than the general population.

A large, federally funded clinical trial for many aspects of women's health, called the Women's Health Initiative (WHI), began recruiting women in 1993. Final results of the WHI are expected between 2005-2007. A component of the WHI is the hormone replacement trial, which compares the health status of postmenopausal women on HRT with postmenopausal women on placebo. Researchers released early findings about HRT and cardiovascular disease in April 2000, however, because the findings were unexpected.

After analyzing the data from the first two years of the trial, researchers discovered that approximately one percent of the 27,000 women participating in the study experienced an increase in cardiovascular events including heart attacks, strokes and blood clots in the lungs. Even though this figure is arguably small, a disproportionate number of that one percent fell into the group of women taking estrogen, not the placebo. Therefore, researchers felt obligated to inform the 27,000 participants about the unexpected risk from taking estrogen because this risk was not known at the beginning of the study and was not part of the participants' informed consent (Harvard Women's Health Watch, June 2000).

Interestingly, a number of recent studies found an increase in cardiovascular events for those women with a history of heart disease who take combined hormones compared to women on placebo. In one study, the Heart and Estrogen/Progestin

Replacement Study, participants on HRT had 50% more heart attacks and were at three times higher risk for blood clots in their legs than women on placebo. During the last two years of the study, however, participants on HRT had 30% fewer heart attacks than women on placebo. Researchers do not know whether this "early harm/late benefit" effect was due to favorable cholesterol changes of women on HRT or other factors. In any event, several studies now indicate that HRT does not prevent additional heart attacks in women with heart disease (Harvard Women's Health Watch, June 2000).

In July 2001, after reviewing these studies, one of the most authoritative groups in heart disease prevention, the American Heart Association, recommended that HRT should not be prescribed to prevent cardiovascular events. This statement is a shift from their previous position in 1999, which recommended that doctors consider prescribing HRT to help prevent heart disease (New York Times, July 24, 2001).

In summary, the best current medical knowledge strongly suggests that HRT does not benefit women with established heart disease and may not protect healthy women from cardiovascular disease. Researchers are continuing to study the role of HRT on healthy women's cardiovascular systems. However, women should know that this study will continue to provide limited knowledge about the benefits of HRT for healthy women's hearts because it does not compare different preparations of

estrogen and estrogen/progestin combinations to placebos (Harvard Women's Health Watch, June 2000).

Side Effects and Risks of HRT

The side effects associated with HRT include continued bleeding for women with uteruses, fluid retention, breast tenderness, and PMS-like symptoms such as nausea and mild depression (Landau et al., 1994; Perry and O'Hanlan, 1992; Utian and Jacobowitz, 1990). Progestin may also decrease the beneficial effects of estrogen for women's libidos (Love and Lindsay, 1997). Risks associated with taking estrogen alone include blood clots and gallstones. As discussed earlier, women with uteruses who take estrogen alone increase their risk for endometrial cancer. Other cancer risks associated with taking estrogen or HRT for more than five years are breast cancer and, for more than 10 years, ovarian cancer.

Most studies conclude that taking postmenopausal estrogen for more than five years increases a woman's risk of breast cancer by 30 percent (Love and Lindsay, 1997). Recent research suggests that taking estrogen with progesterone increases a woman's risk for breast cancer even more, by 40 percent (New England Journal of Medicine, 2000, cited in Englemed Health News). Until recently, medical researchers believed that women who took HRT developed less aggressive forms of breast cancer, but research in Scotland calls that assumption into question. This research suggests that women on HRT do not fare better at recovering from breast

cancer than women who develop breast cancer and do not take HRT (British Medical Journal, 2000, cited in Englemed Health News).

In March 2001, the American Cancer Society (ACS) reported that taking estrogen replacement for 10 years or more may double a woman's risk of dying from ovarian cancer. The ACS evaluated data from a large cancer prevention study, 211,581 postmenopausal women, which followed the participants for 14 years starting in 1982. The women included former and current estrogen users. Those who took estrogen for 10 years or more at the start of the project had more than twice the death rate from ovarian cancer than women who never took estrogen (Harvard Women's Health Watch, June 2001; Washington Post, March 21, 2001).

Many doctors find the results from the ACS study compelling because of its size and its design (Harvard Women's Health Watch, June 2001; Washington Post, March 21, 2001). However, this study is based on observational data and researchers did not gather information on which types of hormones women took, although some researchers believe that most likely the hormone regimens in the ACS study are not the same as those administered today (Harvard Women's Health Watch, June 2001).

Ovarian cancer is rare; the lifetime risk for this cancer is less than two percent. But medicine has not developed early detection tests for ovarian cancer, so the tumor usually spreads before it is detected. About 14,000 women die annually from ovarian cancer (Harvard Women's Health Watch, June 2001; Washington Post, March 21, 2001).

Overall, most medical researchers agree that women can use HRT for the short-term, from 5-10 years relatively safely. Practicing doctors disagree about the relative safety of taking HRT for the long-term, however. Many say that women should discuss that decision with their doctors, taking into account risk profiles and family history (Landau et al., 1994), as well as becoming informed about alternatives to HRT (Love and Lindsay, 1997).

In summary, HRT can help women cope with transient menopausal changes such as hot flashes and vaginal dryness. The benefit of taking HRT for the long-term is to help prevent osteoporosis. However, long-term use is also associated with breast and ovarian cancer. The benefits of taking HRT to prevent cardiovascular disease are inconclusive and may actually put women at risk for developing blood clots, strokes and heart attacks. Women have many non-hormonal options to cope with hot flashes and vaginal dryness as well as to help prevent age-related diseases. Therefore, the current state of medical knowledge on HRT strongly suggests that becoming menopausal does not warrant putting all women on hormone replacement for the rest of their lives. So, why do many doctors prescribe HRT for the rest of women's lives anyway? In the next section, I discuss how various social forces result in some doctors promoting long-term HRT for healthy postmenopausal women.

Sociological Critique of Medical Promotion of HRT

To understand *why* some beliefs become defined as medical knowledge in women's health requires an analysis of the social organization of medicine as well as the social organization of gender (Auerbach and Figert, 1995). In terms of menopause and HRT, I believe that only analyzing the role of gender, the medicalization of women's bodies within a male-dominated profession, does not fully explain the medical definition of menopause as a disease and the promotion of HRT for the rest of women's lives. In my view, the for-profit medical system, the dominant role of medicine in our society, the role of pharmaceutical companies in medical research and marketing of drugs, the media, doctors' training within a historically male-dominated field, and our youth-oriented, heterosexual culture, together, create a set of social forces that construct HRT as a good option for women to manage their postmenopausal health. Consequently, women's choices about HRT are influenced by a sociohistorical context that promotes HRT as a good or even the best choice to maintain their health, despite the inconclusive medical evidence about the long-term benefits and risks.

In general, the medical interpretation of bodily states and medical treatment to normalize behavior increased in power during the last century and extended doctors' social control in society (Conrad and Schneider, 1980; Starr, 1982; Zola, 1982). The dominant role of medicine in society helped legitimate HRT as an important drug to treat menopause. Pharmaceutical companies used this legitimation first to develop

HRT, and then to research and market it as a preventative drug against future health problems (Worcester and Whatley, 1992). Premarin is the most prescribed and most used form of estrogen because it has received significantly more funding from pharmaceutical companies in research than other forms of exogenous estrogen (Love and Lindsay, 1997). Formulations of estrogen and progesterone that cannot be patented receive less research money and use in the United States compared to other countries (Love and Lindsay, 1997). In fact, the European market contains a much larger choice of HRT products than the United States' market (Rozenberg et al., 2000). In short, HRT is big business in the United States and pharmaceutical companies earn hundreds of millions of dollars each year from the sales of this drug (Coney, 1991; Love and Lindsay, 1997).

The media plays a significant role in promoting the benefits of HRT for women's health through its unbalanced reports on HRT, which are often the result of news releases and interviews with pharmaceutical companies (Love and Lindsay, 1997). Pharmaceutical companies hire advertising agencies which increasingly use younger and younger women in ads in women's magazines to tout the benefits of HRT (Love and Lindsay, 1997). The association of young women with HRT is obvious; marketers are sending the message that HRT will help women regain their youth. These ads are reminiscent of the blatant ageist and sexist promotion of HRT by Dr. Wilson in the 1960s and are powerful in a society that values young, female bodies. Arguably, these ads may feed some women's anxiety about growing older.

Ironically, the package insert in Premarin contradicts this marketing of youth; it says: "You may have heard that taking estrogens for long periods after menopause will keep your skin soft and supple and keep you feeling young. There is no evidence that this is so and such long-term treatment may carry serious risks" (Love and Lindsay, 1997:33).

Furthermore, pharmaceutical companies use the media to scare women into requesting HRT to prevent osteoporosis and heart disease (Worcester and Whatley, 1999). Some feminist researchers criticize the medical association of menopause with osteoporosis and heart disease, which are age-related diseases, not caused by the hormonal changes of menopause (Love and Lindsay, 1997; Worcester and Whatley, 1999). By promoting HRT as a healthy way to prevent future diseases, marketers play on menopausal women's fear of aging and becoming debilitated and dependent on others (Worcester and Whatley, 1999). Overall, the media plays an important role in promoting HRT as beneficial for women's health, as a way for women to remain young, and perpetuates the definition of menopause as a disease.

Doctors are trained within a male-dominated institution that historically reflected the interests of middle-class, white men in research and practice (Ehrenreich and English, 1979; Harding, 1986; Hubbard, 1990). Paradoxically, women have been ignored in general health clinical trials while their reproductive organs have received intense medical attention and treatment for more than 100 years (Auerbach and Figert, 1995; Martin, 1987). Some feminists argue that the medical profession

functions as an institution of social control by medicalizing women's unique reproductive capabilities and hormone cycles and then legitimizing appropriate behavior and treatment (Auerbach and Figert, 1995; Lorber, 1997). Like pregnancy and childbirth, the relatively recent medical focus on menopause is part of an overall medicalization of women's normal reproductive functions and, arguably, HRT represents medical social control.

Furthermore, doctors are trained to treat diseases in individual bodies as if they were machines (Turner, 1992) and are not trained in diet, exercise and lifestyle (Love and Lindsay, 1997). Prescribing a pill to treat symptoms and to prevent future diseases is easier and faster than treating the whole patient (Love and Lindsay, 1997). According to Love (1997), the rise of the gynecologists' role within medicine may influence these doctors to prescribe HRT. Medicalizing the transition from reproduction to post production provides doctors an opportunity to monitor women's bodies for the rest of their lives (MacPherson, 1983; Ferguson and Parry, 1998). Once a woman begins taking HRT, she must consult her gynecologist every six months to refill her prescriptions. Women who take HRT are more likely to undergo endometrial biopsies, D&C's and hysterectomies (Love and Lindsay, 1997). Consequently, women who take HRT maintain an on-going relationship with their gynecologists while they take the drug. The aging of the baby boomer population provides doctors with a huge market for this medical surveillance (Coney, 1991; Love and Lindsay, 1997).

In summary, the medicalization of menopause and medical promotion of HRT occurs in a complex social context. Instead of resulting from an objective, scientific rationale for prescribing a drug for the rest of women's lives, the promotion of HRT is a result of a set of social forces that stems from our profit-driven, male-dominated medical system in a society that values medical definitions of bodily states and values youth. Women who become menopausal and seek medical help must decide within this complex cultural and social context whether to take HRT. But how do individual women actually interpret and respond to medical advice about menopause and HRT? The next chapter analyzes women's interactions with their doctors and their decisions about HRT to examine how this cultural, social and medical context shapes their decisions about HRT and their health.

Chapter 6

Doctors and Hormone Replacement Therapy Decision-Making

As discussed in the last chapter, I argue that the medical promotion of HRT stems from the historical, cultural, and medical context in which HRT was first developed and continues to be promoted as important for women's long-term health. I believe that understanding this larger context is important for understanding women's decision-making process regarding HRT. In this chapter, I focus on the doctor-patient interaction to understand *how* the medical construction of HRT as a net positive shapes women's decisions about HRT. Again, even though I focus on interactions, I do not believe that the medical promotion of HRT can be understood only in terms of individual doctors' behavior.

Past Research on Doctors and HRT

In Chapter Five, I reviewed medical studies on the risks, benefits and alternatives to HRT and provided a critique of the politics of HRT. In this section, I review empirical studies on menopausal women's health care use and decisions about HRT.

Studies suggest that while most women experience hot flashes and/or vaginal dryness, they do not seek medical care for these changes (Avis and McKinlay, 1990). However, perimenopausal women tend to discuss period changes with their doctors in the context of another visit, such as an annual exam (Avis and McKinlay, 1990). Past

research suggests that medicalizing menopause strips the social context of women's menopausal experiences to a biomedical condition and negatively affects women's otherwise neutral or positive menopausal experiences (Avis and McKinlay, 1991; Cate and Corbin, 1992; Gannon and Ekstrom, 1993; Kaufert et al., 1986; Winterich and Umberson, 1999). Women who feel neutral or positive about menopause overall must negotiate their views with their doctors, who define menopause by a checklist of negative "symptoms;" the negotiation of these different perspectives may result in dissatisfactory medical encounters and care for menopausal women (Winterich, 1999).

Although the medical establishment has been slow to recognize how and when perimenopause affects women's bodies, their interest in HRT for midlife women continues to increase (Gonyea, 1997; Love and Lindsay, 1997). A survey of doctors on their views about HRT finds that most doctors recommend HRT to their patients (Hemminki, E. et al.; 1993, cited in Rosotsky and Travis, 1996). A recent Gallup Poll of women aged 45 to 65 years shows that the use of HRT increased dramatically from 1993, with 28 percent of women using HRT, to 1994, with 40 percent taking HRT (Gonyea, 1997). However, documenting women's use of HRT is difficult because many women adopt an "on-again-off-again" approach to HRT. They may initially try it to help with menopausal changes, stop using it and then resume again. The medical literature describes this phenomenon as the "compliance problem" (Utian, 1996).

The research suggests that perimenopausal and postmenopausal women want more information on the risks and benefits of HRT and alternatives to HRT (Mansfield and Voda, 1997; Avis and McKinlay, 1991). However, the research on women's views and use of HRT varies by race. Some studies suggest that primarily white women rely on their doctors for advice about menopause and HRT (Pham, Freeman, and Grisso, 1997; Jeffe, Freiman, and Fisher, 1996). African-American women are more likely to turn to friends or family for advice; they seek medical care as a "last resort" and are much less likely to use HRT (Bartman and Moy, 1998; Padonu, et al., 1996; Pham, Freeman, and Grisso, 1997).

Research suggests that Black women are more reluctant to accept a medical view of menopause for a couple of different reasons. Overall, they prefer "natural" remedies toward handling symptoms and they express a greater distrust of their physicians, especially male physicians (Pham, Freeman and Grisso, 1997; Holmes-Rovner et al., 1996). However, white women also complain about the information they receive from their physicians about HRT, and some also complain about male physicians' treatment (Pham, Freeman, and Grisso, 1997).

One study on African-American women's experiences with menopause and HRT suggests that some low-income, African-American women feel that their doctors treated them as if they were "dumb" (Padonu, et al., 1996). When African-American women do use HRT, they are more likely to use it to help with hot flashes than for long-term preventive purposes (Brett and Madans, 1997; Holmes-Rovner et

al., 1996). The scant research on African-American women primarily adopts a medical view of menopause and concludes that African-American women have a "deficit" knowledge about HRT and their long-term risk for heart disease because African-American women die from heart disease at a greater rate than Caucasian women (Brett and Madans, 1997; Holmes-Rovner et al., 1996). These studies conclude that this population needs to be educated about HRT (Brett and Madans; 1997; Holmes-Rovner et al., 1996).

One theme appears constant in the literature. When women of a certain age, usually around 50, consult their doctors, they receive recommendations to begin HRT. One study dramatically illustrates the power of the medical establishment to influence women's decisions to take HRT. Of a convenience sample of 91 mostly white, well-educated women, 20 percent indicated that they take HRT because their doctors recommend it; they did not cite any specific health reasons for taking it (Jeffe, Freiman and Fisher, 1996).

Much of this past research frames women's use of the medical care system and HRT use as individual experiences and decisions. In contrast, my study examines how the social organization of medicine and the social organization of gender influence women's experiences with medical care and decisions about HRT. At the time of the interviews, medical knowledge on the risks of HRT for women's cardiovascular systems and ovaries was less definitive. Therefore, the women in my study who decided whether to take HRT did so without this recent knowledge.

Arguably, the most influential way women learn about the medical approach to menopause is from their doctors. I focus on women's accounts on their interactions with their doctors regarding menopause and HRT to understand women's views about their medical care, how women decide whether to take HRT, and how women interpret their doctors' recommendations.

Interactions with Doctors and Views on Medical Care

Much of the past research on menopausal women's medical care relies on surveys, some of which indicate that women are unsatisfied with their medical care. In contrast, this study asks open-ended questions to understand how social factors influence women's views on the care they receive from the doctors. All of the women in this study, except for two, talked to a doctor or nurse practitioner about menopause. The fact that most women in this study talked to their medical care practitioners about menopausal changes does not necessarily mean that most women found the menopausal transition especially physically difficult and problematic. Instead, this phenomenon most likely reflects our society's reliance on scientific explanations of reality; therefore, it seems only "natural" that women would seek scientific-medical explanation for the experiences in their bodies (Auerbach and Figert, 1995). Women's accounts on their medical care during and after menopause highlight how the for-profit medical system and cultural ideas about gender affect their care and how they perceive their care.

Doctors Who Resist Health as a "Commodity"

As women recount their experiences with their doctors, they discuss what they like and dislike about the care they received regarding menopause and medical advice about HRT. Several women switched doctors because they were unhappy with their care. These women compare what they like about their new doctors with what they disliked about their previous doctors. All of these accounts contain similar themes of characteristics women appreciate in their doctors including taking time, listening attentively and discussing options without overt pressure. These accounts suggest that women appreciate doctors who do not treat their health like a commodity or their bodies like a "machine" (Turner, 1992) and provide suggestions for how medical care professionals can improve their medical care for menopausal women. Out of the 12 women who discuss various aspects about their medical care that they like, seven of these women see either a female doctor or a female nurse practitioner. Many of these women say that their doctor or nurse practitioner is particularly thorough and helpful because she is a woman.

For example, Peggy, a 46-year-old African-American heterosexual, says: "I like going to the female doctor. She just invites questions. She doesn't cut you off. You don't feel like you have to rush through." Peggy also likes the way her doctor discussed HRT with her:

> She just said: "Everybody is different and if you want to try it, you can try it. And if you're not experiencing any major problems of anything, continue with the hormone replacement therapy or not." I like that because she allowed me

> to make the decision. It wasn't like she was pressuring me. Some doctors do do that.

After describing how her previous male physician dismissed her hot flashes because of her relatively young age, Marcia, a 48-year-old Hispanic lesbian, appreciates that her woman doctor listens and is willing to talk about her concerns without rushing. She says:

> The other thing, too, about this gynecologist is that it was an actual give and take and I don't know if it was because it was a woman, but there was an actual listening going on. I could see it in her eyes. She wasn't just "Okay, 10 minutes are up, you're out." I was there for an hour. I presented her with what I read.

And this doctor does not pressure Marcia about HRT, which Marcia says is because: "She's done a lot of her own reading and she wasn't forced by a drug company to push one thing or another, where I think a lot of physicians are." Peggy's and Marcia's accounts suggest that in a for-profit medical system, some women may suspect that their doctors are motivated by profit instead of providing the best care. They may experience doctors' promotion of HRT as pressure instead of sound medical advice. Therefore, as these accounts suggest, when doctors discuss HRT as an option for women to consider without pressuring them, women may experience this advice as quality care.

Like Marcia, Martha, a 56-year-old Caucasian heterosexual, changed doctors because her male doctor told her she was "too young" at age 42 to be experiencing menopausal changes. Martha gives a glowing endorsement of her new woman doctor:

> But this is a female doctor and she's wonderful and she's been very good about listening and hearing what you're saying and that sort of thing….My present doctor has given me excellent care. She explains things really well and she's always happy to answer any questions that I have that she might not have explained. She monitors me and my situation. I think she's done an excellent job.

These findings illustrate how the social organization of medicine and the social organization of gender shape women's perceptions of their care. In a profit-driven medical system where doctors are pressured to see as many patients in as short of time as possible, patients may particularly appreciate doctors who resist these institutional constraints. By taking time, listening, and conducting thorough exams, these doctors show that they value giving their patients quality care as opposed to treating their health like a commodity. In addition, the favorable characteristics of talking and attentive listening are stereotypical feminine characteristics. Dominant cultural ideas about femininity may influence how women interpret the quality of care they receive from their female doctors. Because of gendered expectations, women may associate good care with female health care providers because they are women, even though male doctors have these traits as well. The seven women who see female doctors or nurse practitioners emphasize that these medical care providers are particularly good because they are women while the other five women do not associate the same favorable traits with their male doctors' gender.

On the other hand, one woman, Mary, discusses how efficient her male doctor is in his exams:

> I like him because I feel that he's efficient and the reason I think he's efficient is because one side effect of tamoxifen is women sometimes develop polyps in their uterus and I had huge polyps in my uterus. I started to bleed and that's the first sign that there's a problem and he discovered what the problem was right away. Did the surgery.

Mary associates masculinity and efficiency with medical competency. Men are stereotypically viewed as rational and efficient and her views of his care reproduce that stereotype. However, my analysis is tentative because too few cases discussed this particular gendered attribute with male doctors.

Three women emphasize that they enjoy consulting with their nurse practitioners instead of their doctors. For example, Brenda, a 58-year-old Caucasian lesbian, says: "I've always been satisfied when I was going to the nurse practitioner. She was always very good and gave me time." Similarly, when I ask Anna, a 56-year-old Caucasian heterosexual, about her nurse practitioner, she says:

> I like them much better than the doctors….They tell it to you pretty straight.…I think she answers questions. She gives you more information. She takes about an hour to have you and not just the internal part. It's more. It's not just the (gestures with hand to suggest "in and out").

And Barbara, a 55-year-old Caucasian heterosexual, feels more comfortable talking to her nurse practitioner, especially about vaginal dryness. She says: "I wasn't going to ask him! (laughs)….I think it's tougher asking a man these things."

These accounts point to limitations with the dominant medical approach in a capitalist society. Nurse practitioners are trained to treat the entire patient, not just symptoms within individual bodies. Because nurse practitioners' basic assumptions about health care differ from the biomedical paradigm, they do not treat health as a

commodity. Consequently, they conduct longer, in-depth exams about the whole patient including an assessment of social-psychological factors. Some women in this study appreciate this more holistic approach, which supports past research on the advantages of nurse practitioners over doctors (Fisher, 1995).

In addition, Barbara's account suggests that a female nurse practitioner is easier to talk to about intimate issues, such as vaginal dryness, than a male doctor. This account suggests how the social organization of medicine and gender may influence how women view their medical care, particularly with topics that are concerned very personal. Discussing uncomfortable topics may be especially difficult with a male doctor who adheres to the biomedical paradigm compared to a female nurse practitioner trained in treating the entire person. Because nurse practitioners take more time to talk, patients may develop a more comfortable rapport in which either they or the nurse practitioner can initiate discussions about intimate matters. Conversely, doctors who adhere to the biomedical paradigm and conduct a quick exam, do not allow time for a rapport to develop. Therefore, patients may not feel comfortable initiating a discussion with their doctors about issues that are difficult to discuss anyway, because they perceive that their doctors do not have time. When the topic concerns sexual functioning, a midlife woman may feel even less motivated talking with her medical care professional if he is a man because of stereotypical views about gender and sexuality.

In summary, the women in this study who describe positive medical encounters emphasize doctors and nurse practitioners who take their time with patients, take their patients seriously, and help their patients decide about HRT without pressure. The findings suggest that female doctors and nurse practitioners in particular are valued for their stereotypically feminine characteristics, such as empathy, engaged listening, and thoroughness. Theoretically, these accounts suggest that dominant ideas about gender may influence women's views about the quality of their health care.

These findings illustrate the influence of the social organization of medicine as well. In a capitalist society where health is a commodity, patients may appreciate doctors who resist this value system and take time to provide them with quality care. In addition, women's accounts on nurse practitioners suggest that they prefer their whole person approach to the dominant biomedical approach. Finally, one account suggests how the social organization of medicine and gender may interact and affect how women feel about discussing intimate matters with their male doctors compared to female nurse practitioners. Overall, these accounts provide insight into how medical care professionals can provide a higher quality of care for their menopausal patients.

Problems with Medical Care

Most of the women who talked to their doctors about menopause recount problems they have with their doctors or aspects of their medical care that they do not

like. In this section, I focus on two of the three themes regarding women's concerns: doctors who do not take enough time and disregard women's concerns, and problems with the profit-driven health care system. I focus on the third theme separately, doctors who pressure women to take HRT and do not discuss alternatives, under the next section "HRT Decision-Making."

Do Not Take Time and Disregard Women's Concerns

Sixteen women, over half of the women in this study, say that their doctors either do not take enough time to discuss their concerns about menopause or that their doctors disregard their concerns. These accounts illustrate how the biomedical approach in a for-profit medical system affects women's medical care and how women perceive their care. Also, some accounts illustrate how cultural expectations about gender overlap with institutional constraints of medicine and result in unsatisfactory care for some women.

For example, Mary, a 57-year-old Caucasian heterosexual, whose vaginal dryness causes bleeding during intercourse, says that her gynecologist "seems almost embarrassed to talk about it." She speculates that he feels uncomfortable discussing this topic because he is younger. In general, Mary wishes her doctor would "open up." She says: "I just wish he would be more open to talking. He doesn't act like he's in a hurry like some doctors. You know, some doctors make you feel like you're on a treadmill...but I just don't feel (he is) as open as he should be." Mary's doctor may feel uncomfortable discussing sexuality issues with her because of his gender as

well as his age. This account suggests that younger male doctors may feel particularly uncomfortable talking to older, midlife women about sex perhaps because they assume the topic is too private, or because they have internalized the cultural stereotype that menopausal women are no longer interested in sex.

Ellen, a 53-year-old Caucasian heterosexual, discusses several issues that bother her about her male doctor and her medical care. First, she wonders whether male doctors can really understand female patients:

> You're going to a man doctor. Do they really understand females? I'm really not quite sure. You're going to give them symptoms of how you feel. He's thinking, "It has nothing to do with this." I'm like, "Well, yes it does. It happens every month. That's how I feel every month. So, yea, it has something to do with this." I mean when you talk to them about different things, I think it has no bearing.

Ellen says that a female gynecologist would understand how women's bodies work better than a male doctor. Ellen also wishes her doctor would spend more time explaining HRT and what is happening to her body after menopause:

> They treat the symptoms but they really don't tell you what's going on in your body per se. What happens when estrogen level is being diminished? What happens to all the body functions that it has a control over? I mean, what's happening to me? What can I expect?….Just so you know how to prepare yourself. To know that this is going to be normal.

Ellen's account highlights two issues about the biomedical paradigm as well as the role of gender. Ellen suggests that her doctor disregards her views perhaps because he relies on medical testing and verification rather than her embodied interpretation. This reliance on objective medical measures to interpret symptoms stems from the biomedical paradigm. Objective, scientific tests are more valued in

medicine than patients' interpretations of their bodies. Furthermore, past research suggests that menopausal women complain about the treatment they receive from their male doctors (Pham, Freeman, and Grisso, 1997) perhaps, as the findings suggest, because they feel that male doctors dismiss their concerns and perspectives.

Ellen points out a consequence of being treated as a body instead of a whole person. Her doctor does not take time to fully explain the physiological process of the menopausal transition and therefore does not help her prepare for menopause as a "normal" time of life. Instead, he focuses only on her so-called symptoms. Her account suggests that doctors' fragmented treatment of the body results in a missed opportunity for doctors to educate women about menopause and their bodies. Consequently, some women may feel frustrated and alienated by their medical care.

After we discuss menopausal issues, Barbara says that she dislikes the advice from two male doctors about her prolapsed uterus because both doctors want to remove it. She explains:

> (JW): Are there other options of lifting it?
>
> I think they can repair that. They are not willing to try that. At least the two doctors I've been to aren't willing to try that.
>
> (JW): And why? Why did they say that?
>
> Because it's easier.
>
> (JW): Is that the impression you get?
>
> Yea, it's like, "You're at this age. You don't need it." And they are male doctors.

(JW): Do you say anything back to them or?

No. These are doctors, like, these are god-like doctors. (laughs). There are some doctors I just want to slap around, but not these (laughs).

(JW): So, they are sort of intimidating?

Yea.

Barbara's experience reflects medical assumptions about women's bodies, which views women's reproductive organs as expendable after the childbearing years (Auerbach and Figert, 1995; Ehrenreich and English, 1979; Love and Lindsay, 1997). Barbara's account suggests that women may experience this medical assumption with frustration and doctors' medical authority with intimidation. On the other hand, her account illustrates how women may resist medical authority. Although she feels uncomfortable confronting her two male doctors about their recommended treatment, she says that she plans to ignore their advice and seek another opinion.

Four women, two lesbian and two heterosexual, say that their doctors dismissed their concerns about beginning the menopausal transition because of their ages. These accounts illustrate how dominant ideas about menopause and age as well as gender affect women's medical care. All four women were in their early to mid-40s at the time. Also, three of these women are women of color; one is Hispanic and two are African-American. Research suggests that African-American menopausal women report feeling unsatisfied with their medical care because their doctors do not take them seriously (Holmes-Rovner et al., 1996). Perhaps this finding reflects other minority women's experiences as well.

I did not interpret a pattern according to the doctors' gender or specialty, so I do not analyze the accounts according to these social factors. Instead, I focus on medical assumptions about menopause and age and the disconnect between medical-scientific interpretations and women's embodied interpretations of their menopausal changes.

For example, Martha, a Caucasian, first talked to her doctor about her erratic periods when she was 42. She describes his reaction: "…he just put his hand on my shoulder and said, 'Oh, dear, you're too young for that.' And that was it. He didn't give me a blood test which I know can be done." Martha says she felt:

> Like somebody just wasn't paying attention. Like I knew something was happening with my body. Something was different. And from everything I had read, it must be the beginning of menopause. So just felt as though he was disregarding what I said, making light of my feelings and what I knew was happening with my body. So that was the occasion that prompted me to change doctors.

Martha then switched to a female family practice doctor who gave her a blood test and who took her seriously. This doctor did not comment on her age except to mention that she was beginning perimenopause a little younger than usual.

Similarly, Angie, a 51-year-old African-American heterosexual, had erratic periods and hot flashes when she was 45. She first consulted a doctor at a free clinic who said: "Oh, no, you're not going through menopause, you just need help to get your period back." Angie found this advice confusing. She says that she did not understand why she would want to get her period back if she was beginning the

menopausal transition. She then consulted a male gynecologist who confirmed that she was in perimenopause.

Marcia, a 48-year-old Hispanic lesbian, details a conflict between her embodied experiences and medical assumptions about age and menopause as well. She also points to the organization of medicine to explain her doctor's poor treatment. When Marcia first experienced hot flashes, she had started a stressful job with the federal government. After a year of having hot flashes, she consulted her doctor, an internist, and asked whether she had started the menopausal transition:

> I just began to sweat bullets and thought, "Man, this feels terrible. I just feel awful." About a year later…I mentioned this to my doctor and he, at the time, thought that it was just panic and that it was—because I was too young. I had just turned 40 in 1992, so he thought that I was really kind of young and it probably wasn't anything….I suggested menopause at that point and he said, "Oh no, no, no." He said, "You know, let's just give it a little more time." So, he was initially kind of hesitant to do anything about it.

During the next three years, Marcia's hot flashes increased in frequency and intensity. While she waited to see this doctor again, she had a hot flash and the physician's assistant "looked at me and she said, 'Let's do some blood work right now.'" The results came back two days later and the doctor called her and said, "Oh, yea, by the way, you're perimenopausal." Marcia describes her reaction: "I said, 'Duh! (Laughs). I could have told you this.'"

After Marcia explains her allergic reactions taking Premarin and her decision to consult a woman gynecologist, she reflects on the problems she had with the male doctor:

> It seemed as though, when I tried to interject things I thought I knew or read, that it was sort of like, "Well, what do you know?" (Laughs). "You're taking too much of my time, if you know so much, why don't you prescribe?" And I just kind of got that feeling and I've been kind of ambivalent about going back to him as a regular internist after that and the only reason I don't leave is because I like his PA (physician's assistant) who is a woman….They've been pretty good to me over the years, it was just this particular episode…."
>
> (JW): Was it when you initially said, you know, suggesting it was menopause?
>
> And he was discounting that. It was as though, "Oh, please come off." Kind of like, "Oh, there, there. That's not really what it is, you know. Oh, no, no. You're far too young to be going through this." No, I really know what I'm feeling.

Like Martha and Angie, Marcia's doctor dismisses her interpretation of her bodily experience because of her age and because of her gender. Her doctor implies that her symptoms are "all in her head" (Ehrenreich and English, 1979), not an uncommon experience, historically, for women who consult male doctors. Marcia's account suggests that some doctors continue to hold negative stereotypes about women as irrational and unreliable when presenting their symptoms.

After Marcia's doctor confirmed through testing that she was perimenopausal, I asked if he apologized or acknowledged that her suspicions about menopause were correct. She said that he did not, instead his approach was: "Okay, so you're menopausal, here's what we're going to do. There was no recognition of who I---basically you're another number to him. His practice has gotten very big." Her account suggests that the organization of medical practice, which often leads to quick

appointments, as well as the biomedical focus on symptoms rather than the whole person, may lead to unsatisfying doctor-patient interactions for some women.

These four accounts suggest that some doctors assume that women cannot be experiencing menopause because they are too young. These assumptions reflect common cultural stereotypes about the menopausal woman who stops menstruating around 50. Ironically, these doctors' assumptions about menopause and age prevent them from conducting medical tests, which would disprove their initial medical interpretations. Instead, they discount what women say about their bodies. Most of these women react similarly, they consult with different doctors who conduct medical tests and confirm their embodied interpretations. Although most women focus on the doctor-patient interaction, Marcia also points to the organization of medical practice to explain her doctor's dismissal of her interpretation.

These women resist their doctors' scientific interpretations in favor of their own, which illustrates that the doctor-patient relationship is not monolithic. Although doctors use their medical authority and stereotypical assumptions about gender and menopause to maintain that their patients are too young, these women's reactions illustrate how some women use their agency and resist doctors' diagnoses. This resistance is not without a cost, though, because all of these women describe feelings of frustration and irritation over their doctors' unsatisfactory treatment.

Health Care System

One woman, Kathy, a 56-year-old African-American lesbian, discusses the profit-driven health care system and her sexual orientation as obstacles for receiving quality medical care. Kathy's household income is between $40-50,000, but she is unemployed and is applying for disability because of chronic health problems. Kathy cannot use her partner's health insurance, so she uses free health clinics for her health care. One problem with using these services, however, is that she cannot count on receiving the same form of medication. She explains:

> But the other thing I think I want to say about menopause and poor women…(is that) they (the free clinic) try to give you your medicine, but because they are a free clinic, they don't always have the same kind of medicine all the time. They have what they say is just like your medicine. And that was one of the reasons why I think too that I got the patch, because the doctor said they are not giving us Prempro no more. That patch is what we're going to be getting and we have to change it to the patch….So, I think it's important for, I don't know, I just think it's important for even if it's a free clinic that maybe, you know, people or government or whatever could try to see that the poor women get consistent, the same kind of medication they need.

Kathy says that one consequence of this inconsistent medical treatment is that: "I think they don't go take care of themselves when they are poor and don't have insurance."

Kathy's experiences with the clinic reflect the general problems the poor encounter in finding quality health care in a profit-driven system (Boston Women's Health Collective, 1998). She cannot rely on a consistent form of medication and, as she insightfully notes, those without medical insurance tend to avoid medical care and experience more illnesses as a result (Boston Women's Health Collective, 1998).

When I ask whether she could use her partner's insurance, she say, "We can't use it, and that's the other thing. You know they say that we want special rights. We don't want special rights. We just want what everybody else wants." Kathy points out that her partner pays the same proportion of taxes that everyone else in their income bracket pays, yet, she "can't even use her insurance card if I'm dying." Kathy's insights highlight some problems poor lesbians encounter trying to secure quality medical care. Because our society does not recognize same-sex unions, lesbians do not have the same status and rights as married heterosexuals. For Kathy, this prejudice and discrimination affects her health and quality of medical care.

Summary

Women in this study give three primary reasons why they feel unsatisfied with their medical care regarding menopause: their doctors do not take time and dismiss their concerns, the health care system for the poor is inconsistent, and they feel pressured to take HRT, which I discuss in the next section. As women discuss these reasons, other social factors clearly play a role in women's unsatisfactory medical care including issues of gender, race, sexual orientation and class.

Theoretically, these findings suggest that the social organization of medicine and cultural assumptions about gender may result in unsatisfactory medical care. In particular, doctors who internalize cultural assumptions about menopausal women and age may discount women's concerns and interpretations and, paradoxically, avoid conducting medical tests, which would disprove their initial medical interpretations.

Furthermore, cultural assumptions about legitimate sexual relationships can result in limited options of medical care for poor lesbians.

Hormone Replacement Therapy Decision-Making

In this section, I analyze women's accounts about HRT including why women do or do not take or try HRT and how long they plan to take it. I provide these accounts to illustrate how women's decision-making regarding HRT is a social process and cannot be reduced to an individual issue. Obviously, because I interviewed women after they decided whether to take HRT, I can only examine what they say their doctors told them about it and how they decided whether to take it. In other words, I cannot examine their decision-making process as it unfolded. Instead, I analyze their decisions as they discuss them retrospectively. I argue that their accounts reflect a social process of decision-making between women and their doctors in a cultural and social context that promotes HRT as a "good" decision.

In Chapter Five, I described how medical studies and the media coverage of those studies construct HRT as a net positive for women's health, despite the increasingly inconclusive benefits for women's hearts and risks for cancer. In this section, I provide empirical evidence on women's interactions with their doctors regarding HRT and why women say they take HRT. These accounts highlight the important role doctors play in influencing women to take HRT. Some of these

accounts on doctors' pressure to take HRT also illustrate why some women are unhappy with their medical care

Overall, 14 women currently take HRT and another woman plans to start taking it soon. Five other women tried HRT and discontinued it; two started Evista, a selective estrogen receptor modulator, instead. Of the 14 women who currently take HRT and the woman who plans to start taking it, only two are lesbians. Perhaps such a smaller number of lesbians who take HRT reflects lesbians' general mistrust of the medical system (O'Hanlan, 1995). Some research suggests that this mistrust is a consequence of prejudice and discrimination within medical practice and a general oversight of lesbian health issues within medical research (O'Hanlan, 1995). Consequently, lesbians may either seek medical care less often or be more skeptical of their doctors' recommendations to take HRT.

Why Women Do Not Take or Try HRT

In the interviews, many lesbians say that they do not think HRT is natural or safe. For example, Andrea, a 49-year-old African-American, says that she does not "want a whole lot of…chemicals" in her body and she does not want to "compromise one or two organs for a theory." Similarly, Sally, a 56-year-old Swedish-American, says: "I wanted to do it natural because my mother did it natural. I didn't want to take any chemicals or anything…I don't like taking drugs."

Janet, a 52-year-old Caucasian, questions whether HRT contributes to breast cancer; she says:

> I just have talked to women who just felt like hormone replacement therapy has just made all the difference in the world. But I also have friends who now are getting breast cancer who feel like the hormones really precipitated that. You know, there's still so much that we don't know about it….

Kate, a 60-year-old Caucasian, has valuable education and income resources to critically evaluate the media coverage and medicalization of menopause. Kate says that she never wanted to take estrogen because she questions its safety and dislikes the "conflicting literature" about its benefits and risks. Kate is the only woman in this study who says that the conflicting literature leads her to *not* take HRT. If women discussed conflicting literature, they generally said that the benefits seem to outweigh the risks. I ask Kate about her interpretation of the magazine and newspaper articles on HRT she has read; she explains:

> Well, if I listened to doctors, I'd be on it….I've always been very independent in my own thinking and I think I was, unlike my mother's experience where thinking doctors were God and everything they said you should do. They screw up. I mean research demonstrates that time and time and again….When I was using herbs (which contained natural estrogen), I was getting some headaches, I had the breast cysts. To me that says, "Listen, you are not a candidate for estrogen replacement." And…about a year ago, I went for another bone density scan and they tell me I have the bones of an 18-year-old. So I'm not going to take it.

In addition, Kate is the only woman to explicitly say that she rejects viewing menopause as a "disease." She says that articles describe menopause with "symptoms" and that symptoms only come from diseases. Kate explains that, in part, because of her job in public relations and her interest in the media, she follows the media coverage of menopause closely. Kate is well-educated, she has a Master's degree, and is one of the few women in this study to earn a combined household

income over $100,000, so she can afford to pay for her own bone density tests. This account highlights how women with resources are well-situated to critically evaluate and resist the dominant construction of menopause as a disease.

Similarly, several heterosexual women say that they do not think HRT is natural or safe. For example, Jane, a 61-year-old Caucasian, does not want to take HRT because she is a "natural foods freak and I figure the more you can stay from artificial anything, the better off you are." Susan, a 58-year-old Caucasian, says that she is "very much in the holistic health care way" and had acupuncture treatment for three or four years to help her through the menopausal transition. She also takes calcium supplements and exercises frequently to maintain her bone health.

In summary, the women in this section never tried HRT because they do not think it is safe, do not like taking medication, and prefer natural alternatives to HRT, such as herbal treatment, acupuncture, diet and exercise. Many of these women are lesbians, which may be due to the general disenfranchisement lesbians feel from the medical system (O'Hanlan, 1995). Also, one lesbian woman's account illustrates how women with education and income resources can critically evaluate and educate themselves about menopause and HRT.

Starting from lesbian women's perspectives (Harding, 1991), these accounts suggest that lesbians reject and resist the medicalization of menopause. Perhaps lesbians disagree with medicine's definitions of their reproductive organs as pathological. My interview with Brenda, a 58-year-old Caucasian, may shed some

light on this issue. After I turned the recorder off, we discussed her views on HRT further and she described how a lesbian health newsletter she receives that provides information about how other lesbians cope with menopausal changes without HRT. These women rely on exercise, nutrition, acupuncture, herbs and vitamins. She said reading this information made her interested in stopping HRT, but her doctor convinced her to continue taking it, which I discuss later. Future research could help illuminate to what degree lesbians reject the medicalization of menopause and, if so, provide further information about why.

Why Women Stopped HRT

Three women, two lesbians and one heterosexual woman, took HRT previously but then stopped because of the constraints associated with free health clinics and because of breast cancer experiences. For example, Kathy, a 56-year-old African-American lesbian, stopped taking HRT because the free clinic no longer supplied Prempro, instead, they offered the patch. Kathy tried the patch "but it would never stay on my body (laughs)." So, Kathy stopped using it and said that she felt fine. She did not have any hot flashes, vaginal dryness or panic episodes. She says she would rather not take it any longer because she "takes enough pills and medicine a day, I don't need it."

The other two women, Selena, a 59-year-old Caucasian lesbian, and Ellen, a 53-year-old Caucasian heterosexual, stopped taking HRT because of breast cancer. Selena took a high dose of estrogen for six years and then tried to stop taking it

because she felt better physically and emotionally. Her hot flashes and mood swings returned, so she switched to Prempro. About six months later she was diagnosed with an aggressive malignant breast cancer tumor, which had not been palpable three months earlier. She had surgery immediately and stopped taking HRT.

Because of Ellen's chemotherapy treatment for breast cancer, she became menopausal and suffered from extreme and frequent hot flashes (Cobleigh et al., 1994; Love and Lindsay, 1997). She consulted her doctor for help, who had recently read a medical article that indicated that HRT is safe for women who do not have estrogen-growth breast cancer (Cobleigh et al., 1994). Ellen's cancer tested positive for progesterone (Love and Lindsay, 1997). Ellen consulted with her oncologist who had read the same medical article and agreed that she could take HRT. He also told her that decreased levels of estrogen after menopause can "cause life threatening conditions." So, Ellen took HRT for five years to alleviate her hot flashes and vaginal dryness and to protect her heart and bones.

Recently, a new oncologist in her doctor's practice told her to stop taking HRT because it could cause the breast cancer to return. Ellen stopped taking HRT a couple of months after this visit and now says she feels scared to take it, because of the breast cancer risk. She feels scared *not* to take it, however, because of the previous doctor's warning that: "(I could) have life threatening problems (if I) didn't take it."

Unfortunately for Ellen, the confusing medical literature on the safety of HRT for breast cancer survivors and her doctor's strong word choice about HRT preventing "life threatening conditions" have left her frightened about how to manage her health. Because her doctor overstates the benefits of HRT for preventing osteoporosis and heart disease, Ellen says she feel confused about what she should do to maintain her long-term health.

The accounts in this section suggest that the reasons women in this study stopped taking HRT were due to external reasons. Kathy stopped taking it because of the constraints associated with free clinics; she could not get the medication she had been taking. Both Selena and Ellen stopped taking HRT because of breast cancer. However, Kathy and Selena feel physically fine without HRT while Ellen is afraid she is jeopardizing her future heart and bone health by not taking it.

Why Women Take or Try HRT: Doctors and Family Recommend it

Overall, 14 women in this study currently take HRT and another woman plans to start taking it soon. The overwhelming primary reason most women in this study who currently take HRT is because their doctors recommend it. This finding supports past research which suggests that some women take HRT because their doctors recommend it, not for specific health reasons (Jeffe, Freiman and Fisher, 1996). These accounts provide insight into how some doctors may persuade their patients to take HRT through persistent discussion and power-laden language, and overemphasizing the benefits of HRT and not discussing alternatives. Furthermore,

some of these accounts illustrate how family and friends influence women to take HRT as well.

Persistent Discussion and Power-Laden Language

Many women say that their doctors either consistently discuss HRT with them, even in one case when the woman clearly states that she is not interested, or that their doctors pressure them to try or stay on HRT. Even though not all women comply with their doctors' recommendations, these accounts illustrate how the doctor-patient interaction creates a context that influences women decisions about HRT.

For example, Kate, a 60-year-old Caucasian lesbian, says that before her periods stopped, her female gynecologist consistently talked to her about HRT as a medication she should take to maintain her bone and heart health. Kate explains:

> I argued with my gynecologist who I saw for about 10 years, argued with her every time I saw her. Because every time I saw her she was talking about hormone replacement therapy. I eventually went through menopause and I kept saying, "No way." And she kept talking about in terms of osteoporosis and heart and all this and I just said, "Look," finally after years of discussion with my gynecologist, I said, "Look, if it will shut you up, I will go and have a bone density test done. If they tell me that I've got osteoporosis or look like I'm on my way to it, I will reconsider." I went at my own expense because, of course insurance wouldn't cover it because that was considered experimental at the time, I went and had it and everything was normal. So I figured, "Get off my back, I'm not taking it."
>
> (JW) And what did she say?
>
> Well, she still talked about it….
>
> (JW) And how did you feel when she kept bringing it up?

> Annoyed you know, but she was such a good-natured person. I mean I really couldn't get angry with her….She felt as a physician she had to do her duty and try to convince me to do this.

Kate's account illustrates two problems with the medical promotion of HRT. First, her doctor's consistent promotion of HRT results in Kate spending her own money for a bone density test to provide medical evidence about whether she needs hormone treatment. Although Medicare started covering bone density screening tests in 1998 (National Osteoporosis Foundation: www.nof.org), not all private insurance companies cover the test costs, which range from $150-$350 (Intelihealth: www.intelihealth.com). Medicalizing menopause essentializes women's bodies as inherently pathological (Love and Lindsay, 1997; Parry and Ferguson, 2000), as if all women's bodies pose the same risks for osteoporosis and heart disease. As this account suggests, some women who resist this medicalization may have to undergo significant personal costs to maintain their resistance.

Second, when Kate's bone density test showed healthy bones, Kate's doctor persisted in promoting HRT. I asked Kate why and she said: "I think she routinely did this with all her patients. Obviously, she believed in it." Also, heart disease runs in Kate's family; perhaps her doctor promoted it for long-term heart health. In any event, Kate felt "annoyed" by her doctor's insistence. Kate's insightful comment that her doctor's medical training results in her doctor's strong belief and advocacy of HRT shows the complexity of the medical promotion of HRT. Reducing medical pressure about HRT to individual doctors' behavior overlooks the complex ways that

the medical establishment trains doctors about the benefits of HRT, continually researches HRT, and promotes HRT through medical writings.

Several women discuss how their doctors strongly recommend, and in some cases, pressure them to take HRT. These women all agree to use HRT primarily because of their doctors' recommendations. These accounts illustrate how doctors tap into their medical authority to persuade women to take or continue taking HRT through power-laden language. For example, when Carol, a 71-year-old Caucasian heterosexual and a retired nurse, first began HRT, she spotted. She called her doctor's office and he was out-of-town. Because she believed it "seemed like the smart thing to do," she stopped taking it. She describes her doctor's reaction:

> In fact, when I stopped taking it that time, when I had the bleeding, Dr. Jones is my gynecologist and he said to me, checking off everything as he went down the checklist, and he said, "Are you taking your Premarin?" I said, "No." I had stopped taking it because of the bleeding and he was out-of-town, so I just quit taking it. And then I knew it was the lowest dose so I just slowed down and I just didn't take it any more. And he said, "Well, I want you to take it and I don't want you to get osteoporosis." And he got really upset with me….
>
> (JW) Why was he upset with you?
>
> Because I stopped taking it totally. And he had ordered. So then I started taking it again.

Carol's doctor uses his medical authority through power-laden language; he tells Carol he "ordered" Premarin for her and that he expects her to follow his orders. Carol says that her response was: "I try to be obedient and do it because it's the thing the doctor says I'm supposed to do." Although Carol says that she would rather not

take HRT or any medications, she says that she knows she should take HRT for her bone health. This account illustrates how medical authority is enforced through language centered on power in the doctor-patient interaction: Carol's doctor "orders" her and she tries "to be obedient." This account suggests that women may comply with their doctor's recommendations, despite their preference to avoid medication, because they feel obligated to follow their doctor's orders.

Overemphasis of Benefits; Do Not Discuss Alternatives

Many women's accounts illustrate how some doctors may over-emphasize the alleged benefits of HRT and downplay or ignore the risks associated with HRT. Some doctors dismiss alternatives to HRT as well. One consequence of the medicalization of menopause is that doctors view HRT as the only legitimate "treatment" for menopause (Parry and Ferguson, 2000; Worcester and Whatley, 1999). Consequently, so-called alternatives to HRT are viewed as less effective.

For example, Brenda, a 58-year-old Caucasian lesbian, has been taking HRT for the past seven years. She initially took HRT for hot flashes and was interested in stopping it, but her doctor persuaded her to continue it. She says that she was interested in alternatives to HRT: "I think I was sort of willing to look at something else and she (her doctor) convinced me that I don't need to." Brenda's sister had breast cancer but her family also has heart disease, so she feels conflicted about continuing HRT. She explains what her doctor said to persuade her to stay on hormone therapy:

> …my doctor explained it, she said, "If you take 1,000 women here that use Premarin, 1,000 women that don't, this 1,000 is going to live longer because they are taking Premarin." She said, "This group will not because of heart circulation and that sort of thing." And she said, "This group that takes Premarin will have a slight increase in breast cancer but looking at it overall, it's a healthier group of women." So that made me feel better just last year. The last time I went.

Brenda's doctor persuades her to continue taking HRT based on the best observational data available at that time. However, for years the research on the benefits of HRT for women's cardiovascular systems has been suggestive and conflicted (Love and Lindsay, 1997). Nevertheless, her doctor frames HRT as the best option for her long-term health. This examples provides a clear illustration of how a doctor's over-emphasis of the supposed benefits of HRT for long-term health maintenance persuades a woman to continue taking it, even though she was interested in alternatives and may be at risk for breast cancer.

Similarly, Sandy, a 57-year-old Caucasian heterosexual, takes HRT because her doctor recommends that she take it for the rest of her life because the benefits outweigh the risks. Sandy questions this advice during the interview when she asks: "But is this just from something he's read? Or what? Because I don't think there's really anything to back it up." Sandy says that she wishes her doctor would run some tests to determine whether she really needs HRT. She participated in a bone density test at work twice over the years, and both tests showed that her bone density is "off the chart." Sandy exercises every day and her weekly exercise routine includes spinning, walking, weight-training and yoga.

Therefore, Sandy wonders why she needs HRT. She explains that she asked her doctor about going off of HRT "many times" but she stays on them because: "They keep convincing me I should do that." After I suggest that Sandy share her concerns with her doctor, she says: "And that's what you try to do but they just keep (pushing it)." If Sandy's doctor stopped advocating HRT, she would stop taking it.

Several women say that they wished their doctors considered and discussed alternatives to HRT. For example, Anna, a 56-year-old Caucasian heterosexual, took Rejuvex, a vitamin supplement, which she says: "I really like…I thought it was great. I was feeling really good." When she told her doctor about it, she "poo-pooed it like crazy and told me I should go on (HRT)….she (her doctor) thought, 'That's just one of those scams.'" Anna followed her doctor's advice, stopped taking Rejuvex, which she really liked, and started HRT, which caused her physical discomfort and heavy bleeding.

And Courtney, a 60-year-old African American heterosexual, says:

> I wish that they would consider more alternatives to estrogen replacement. There are several over the counter medicines that you can use for hot flashes, also calcium for your bones. And I think they need to do more research with women using these (alternative) drugs to determine that they are effective.

Similarly, Pat, a 64-year-old multiracial heterosexual, says that she wishes doctors "weren't so narrow minded about herbal stuff, comparing to chemical stuff."

The fact that women and doctors frame options to HRT, such as vitamins, exercise, diet, and herbs, as "alternatives," demonstrates how HRT defines the medical approach to menopause. These accounts highlight an important and

complicated issue with medical research on HRT and "alternatives" to HRT. As discussed, because pharmaceutical companies fund research on Premarin, little research is conducted on different preparations of exogenous estrogen or the role of herbs (Love and Lindsay, 1997). Because doctors do not have access to data about the effectiveness of other options compared to HRT for women's long-term health, medical consultations about menopause focus on using HRT. Furthermore, doctors may believe that monitoring a patient's "compliance" with a prescription is easier than monitoring patients' exercise and diet regimens (Love and Lindsay, 1997).

The Role of Family and Friends

As women discussed their decision-making process regarding HRT, many also discussed the role of family and friends in influencing their decisions. These accounts illustrate how the decision-making process extends beyond the doctor's office.

Although Peggy, a 46-year-old African-American, never took HRT, at the time of the interview she had a prescription for it. She says that her doctor talks to her frequently about HRT because "she just wants me to be informed." Peggy has never tried HRT because when she first became menopausal, she felt scared about it. "Everybody" was telling her to take it. She says:

> I think there is this big scare though. Immediately, you're in menopause, you got to take these pills and that's what I was going through. I've got to take these pills.
>
> (JW) You thought that?

> I did. I really did because everybody was telling me that. Because I hadn't really read up on information enough to know that I have a choice. And ask your doctor and see what their concerns or opinions are about this kind of literature and will it help you in the long run.

Peggy's account illustrates the climate in which some women experience menopause. She felt pressured to take HRT by her family and friends who discussed menopause as a time to begin HRT.

Also, in part, because her doctor continually talks to her about it, she decided to try it. Her doctor suggests it for her bone and heart health and says it would help eliminate her hot flashes and may help her energy level. Peggy told her doctor that: "I don't have those (hot flashes) and they just happen so rarely now, but she said, 'Well, just try it and see if it makes you feel better.'" Peggy then explains that she feels curious to try it because sometimes at night she finds falling asleep difficult. Her doctor told her that HRT may help with that as well. Peggy says that because her doctor recommends HRT, she will try it for three months and then see how she feels.

As discussed, Anna takes HRT because her doctor "pooed-pooed" the vitamin supplements she had been taking. She takes HRT to alleviate hot flashes and vaginal dryness, but says that she does not have osteoporosis, heart disease or breast cancer in her family. She says that her doctor emphasizes taking HRT to prevent osteoporosis, however. When I ask how long she plans to stay on HRT, she says: "I don't know if you have to take them forever or if you can quit sometime. My sister who is 70 is still taking them and she takes the same type of dose that I do." Her sister, who is married to a doctor, tells her: "You really should be on them."

Similarly, Chiyo, a 64-year-old Japanese-American, says that her friend stopped taking HRT at the age of 70 after she had taken it for 10 years. Shortly after discontinuing it, she fell and suffered a fracture. Chiyo says that her friend "always tells me and also my sister in Canada, 'Don't stop taking it. Keep taking it." These accounts illustrate how women's decisions about HRT are not only influenced by their doctors' perspectives, but also can be shaped by family members' and friends' views.

Summary

Most women in this study who take HRT say that they take it because their doctors recommend it. Others discuss the influence of family and friends. These women's accounts reveal how the decision-making process regarding HRT is a social process between women and their doctors set in a cultural and social context that frames HRT as a "good" choice. Women do not simply conduct a rational cost-benefits analysis after their doctors present them with the information on HRT. Because most doctors promote HRT as a net benefit, it is not possible for women to decide for themselves in a climate where HRT is promoted so strongly by some doctors, and women's friends and families. This study provides empirical evidence about how doctors, family and friends create a set of social forces that casts HRT as a net positive.

This analysis also calls into question the nature of "choice" for some women regarding HRT. Many feminist health researchers argue that women should be given

the choice about HRT and should decide for themselves instead of just following their doctors' recommendations (Love and Lindsay, 1997; McCrea, 1983; Parry and Ferguson, 2000). However, as these examples suggest, many doctors frame women's choices about how to manage menopausal changes and maintain long-term health solely in terms of HRT. Women are not deciding among many options, in other words, but are making a limited choice about whether to take HRT. Furthermore, in a social and medical climate that promotes HRT, some women may feel pressured or pushed to choose HRT. The conflicted accounts by Carol, Sandy, Peggy, and Anna illustrate the difficulty of framing HRT as an individual choice. These women feel obligated to follow their doctors' recommendations because of their doctors' medical authority. Finally, not all women have the time or resources to educate themselves about the risks and benefits of HRT as well as alternatives, as some health researchers strongly suggest (Love and Lindsay, 1997).

Conclusion

This chapter examined how the social organization of medicine and the social organization of gender may affect women's experiences with and perspectives of their medical care and decisions about HRT. In general, the findings in this chapter suggest that our society's profit-driven medical system, which treats health like a commodity, may result in unsatisfactory health care for some women. Gender may play a role in how women view their medical care and in how they are treated as well.

Women prefer female doctors and nurse practitioners who provide care in a stereotypical feminine way, through attentive listening, talking and empathy. Women's accounts suggest that some male doctors, on the other hand, discount their concerns and treat them as unreliable sources of knowledge about their bodies.

This chapter also illustrates some problems with the medicalization of menopause and casting women's decisions about HRT as an individual choice. Doctors who advocate HRT for the long-term normalize dominant medical definitions of women's post-reproductive states. Defining menopause as a problematic health time essentializes and pathologizes women's bodies because it defines all women's post-reproductive states as a time that warrants medical surveillance (Harding, 1997) to prevent osteoporosis and heart disease, as if all women are equally at risk for these age-related diseases. Doctors enforce their medical authority by persistently discussing HRT, through power-laden language, overstating the benefits of HRT and avoiding discussions about alternatives to HRT.

A consequence for women's lives is that some feel conflicted about their decisions and what is best for their current quality of health and their long-term health. Some women feel obligated to take HRT even though they do not want to take it, and could be increasing their risk for cancer. Therefore, framing HRT as an individual choice is problematic in a social and medical context which may push some women to choose HRT. But the findings suggest a difference by sexual orientation. Lesbians are much less apt to take HRT or to follow doctor's advice

about HRT. This finding could be a reflection of lesbians' mistrust toward the medical establishment in general (O'Hanlan, 1995) as well as a rejection of the medicalization of menopause.

Chapter 7

Conclusion: The Social Meaning of Menopause

By documenting a diverse sample of women's lived experiences with menopause and midlife sexuality, this study contributes to a burgeoning public discourse on menopause as a normative event. Many feminist researchers call for such research to counter the dominant cultural construction of menopause as a negative time in women's lives (Mansfield and Voda, 1997; Parry and Ferguson, 2000). One challenge for developing a positive public discourse based on women's perspectives is framing menopause as normal *and* possibly difficult for some women (Parry and Ferguson, 2000).

As this study argues, understanding *why* some women's experiences are difficult requires knowing more than how many physical and emotional changes they experienced during the menopausal transition. Reducing women's menopausal experiences to an individual, biological event overlooks the cultural ideas and social arrangements that may contribute to some women's difficult experiences. Furthermore, framing menopause as an individual, biological event supports the current medical promotion of HRT to alleviate the difficult "symptoms" associated with menopause. This medical approach pathologizes women's bodies and reifies the cultural idea that female hormones are responsible for women's behavior and emotional states.

In contrast, this study emphasizes the social meaning of heterosexual and lesbian women's experiences with menopause during this current historical and social time. The findings on women's expectations and experiences with menopause, midlife sexuality, doctors and HRT, demonstrate that understanding *how* and *why* women view menopausal changes requires documenting women's perspectives and analyzing the role of cultural ideas and social arrangements. I am not arguing that biological changes are completely irrelevant or pure social constructions for women's experiences with menopause. Instead, I argue that by understanding how heterosexual and lesbian women's menopausal experiences are social experiences, sociologists can broaden their understanding of the meaning of menopausal changes in women's lives as well as how to improve some women's difficult experiences.

For example, the findings on women's experiences with menopause suggest that some women view the physical changes caused by menopause as "no big deal" or not difficult. Perhaps for those women who expected menopause to be a difficult emotional time but do not experience it that way, the physical changes of menopause are relatively easy to manage. For other women, stressors of midlife are more important to them than the physical changes of menopause. In these cases, women view the physical changes associated with menopause as inconsequential for their lives. These accounts demonstrate why only knowing women's rates of physical change does not explain how women view those changes in their lives. Also,

research that only documents rates of change implies that change is unpleasant or difficult for women, contrary to the findings of this study.

Furthermore, for those women who describe difficult experiences, those experiences are not easily understood in terms of women's rates of physical and emotional change. For example, some women describe heavy bleeding as difficult at work because of the expectation that menstrual blood should be controlled and hidden. And, for those women who say that vaginal dryness affected their sexual relationship, they also describe poor relationship quality or narrowly define "real" sex as intercourse. As this study suggests, women's accounts on how they experience menopausal changes and what those changes mean to them highlight the social nature of their experiences. These accounts point to social factors and cultural ideas about menopause, gender and heterosexuality as important for understanding how women experience menopause and midlife sexuality.

In turn, understanding *why* some women's experiences are difficult or problematic, points to social factors that must be addressed to improve women's experiences. For example, the findings suggest that improving women's socialization about menopause through positive, detailed education about the physiological changes that can accompany menopause may help women prepare for menopause as a normal time of life. The findings also suggest that educating men and women about how to communicate and deal with changes that may affect sexual functioning could improve some heterosexual women's sexual relationships during menopause. In

addition, for women's experiences with doctors and HRT, educating doctors to treat women with respect and to provide balanced, extensive information about HRT and alternatives to HRT may help improve women's medical care during menopause. All of these examples point to social factors that need to be addressed to help improve women's menopausal and midlife sexuality experiences.

Theoretically, the findings illustrate how dominant ideas about menopause, gender and femininity influence women's experiences with menopause and are reproduced through social interactions. However, the findings also illustrate how some women use their agency to resist these ideas. Throughout my analysis of heterosexual and lesbian women's accounts on menopause, midlife sexuality and interactions with doctors, I illustrate how dominant ideas about menopause and gender are linked to assumptions about heterosexuality.

The value of this analysis is not only for theoretical purposes. In particular, these findings illustrate the importance of attending to a diverse sample's perspectives and experiences. By including lesbian women's perspectives, this study illustrates how attending to and valuing these perspectives *not only* reveals the myriad ways that oppression is experienced *but also* offers powerful suggestions of how that oppression can be overcome.

For example, the positive accounts on the menopausal transition suggest that it can be a time of liberation and freedom from physical discomforts associated with menstruation. Some women describe menopause as "no big deal" and a "natural

phase of life." Conceptualizing menopause from these women's perspectives reclaims it as just another stage in women's lives and does not associate it with women's sexuality, attractiveness and self worth.

The accounts on female sexuality suggest that defining sex based on lesbian women's views would redefine sex as intimate talking, touching, hugging, and kissing and would elevate the importance of the female orgasm. I do not intend to essentialize female sexuality, but perhaps sex based on women's orgasms would radically transform the ways that men and women have sex and would allow more heterosexual women to experience their sexuality fully.

These examples illustrate how thinking from lesbian women's lives (Harding, 1991) would transform cultural ideas about gender and femininity, and social relations. Even though I focus on sexual orientation, the findings also illustrate the importance of race and class for women's experiences with menopause, midlife sexuality and interactions with doctors. Throughout the following sections I review the major empirical findings of this study and summarize the theoretical contributions. I conclude this chapter by describing the social policy implications of this research.

Menopausal Expectations and Experiences

In this study, my findings support past research on women's expectations with menopause because many heterosexual and lesbian women, almost half, in this study say that they had negative expectations about menopause. Although both lesbian and

heterosexual women's negative expectations reflect "old wives' tales" about menopause as a time when women become irritable or "crazy," only heterosexual women linked menopause with a lack of sexuality. Theoretically, this finding suggests that cultural ideas that link women's sexual attractiveness with their reproductive status may more negatively affect heterosexual women's expectations about menopause.

Many women say that they did not have any expectations about menopause but I believe it is significant that only four women say that their mothers prepared them to anticipate menopause as a "normal stage of life." This finding suggests that women who are taught to anticipate menopause as "not a big deal" may be more likely to ignore "old wives' tales" in favor of the firsthand advice from their mothers. In other words, dominant negative cultural ideas about menopause, which prepare women to anticipate it as an unpleasant time of life, can be replaced through positive education.

The findings suggest that the social meaning of heterosexual and lesbian women's experiences with the menopausal transition is linked to stressful events that often occur during midlife, stress from dealing with heavy bleeding and hot flashes, particularly at work, race and poor treatment from doctors, and memories of past traumas. Some women may reject the cultural story about menopause and find the menopausal transition relatively easy if they expected it to be emotionally difficult.

These findings illustrate the importance of documenting the social context in which women experience menopause to fully understand the meaning of women's menopausal experiences. Documenting rates of physical and emotional change reduces the meaning of those changes to a biological event. The menopausal body must be put into social context to understand *why* women view their experiences as difficult or insignificant.

The findings on heavy bleeding and hot flashes in public settings highlight the role of social expectations about gender, women's bodies, menstruation and reproductive status. Because heavy bleeding and hot flashes can be impossible to control and hide, women may experience them with discomfort and embarrassment because they signal to others that they are embodied, aging females. Furthermore, heterosexual women who have internalized dominant cultural expectations about gender, femininity and youth, may find hot flashes embarrassing because they symbolize to others their advancing ages and post-reproductive status.

Sex and Intimacy

The findings on the social meaning of menopausal changes for women's sexual functioning provide further illustrations of the link between biology, female bodies and culture. Many women experienced physiological changes during and after menopause that are relevant for sexual functioning, such as vaginal dryness and libido and orgasm changes. However, the meaning of those changes for women's sexual

pleasure depend on sociocultural factors such as the status and quality of sexual relationships, sexual orientation and definitions of sex.

The different meanings of menopausal changes by sexual orientation reflect how dominant cultural ideas of femininity and heterosexuality influence heterosexual women's sexual functioning more significantly than lesbians. For example, more heterosexual women describe vaginal dryness as problematic for their sexual enjoyment because of the emphasis on intercourse in sex instead of other activities that would stimulate lubrication. In contrast, lesbian women describe talking to their partners about how to make sex more enjoyable and say that they try different things as well. In part, because lesbians have more flexible definitions of sex, vaginal dryness does not pose the same type of problems for their sexual functioning and relationships as it does for heterosexual women.

Theoretically, these findings illustrate how dominant cultural ideas about gender and heterosexuality become reproduced through interactions. Women (and men) who follow cultural scripts of heterosexual sex, which define sex from a male point of view, bolster stereotypical cultural ideas about gender and heterosexuality as "normal" through their interactions. The findings suggest that some consequences include women who believe that female orgasms are less important than men's and women who fake orgasms so that their husbands do not "feel bad" about their sexual performance. Also, some women do not enjoy intercourse and a few women do not mind that their husbands' health problems mean they cannot have intercourse

anymore because they never fully enjoyed it. These findings illustrate how social expectations about gender and heterosexuality may limit some women's sexual fulfillment, pleasure and agency.

On the other hand, the accounts from some heterosexual and many lesbian women offer insight about how sexual subjectivity can be developed as well as how women are agentic in their sexual relationships. Women's accounts on learning about masturbation and orgasms suggest that women can and do learn about their bodies and their sexual desire throughout their lives. In addition, women act on their desire by talking about sex with their husbands or partners, initiating sex, and finding pleasure in their bodies. Some women discuss sensual non-orgasmic touching as well, which suggests that women enjoy a variety of sensual and sexual contact. These findings provide empirical evidence about how women develop and use sexual agency as well as provide information on how sexuality researchers could reconceptualize sexuality in their research to more fully reflect women's perspectives.

Doctors and HRT Decision-Making

The findings from this study on women's interactions with their doctors and decisions about hormone replacement therapy illustrate how the social organization of medicine and the social organization of gender medicalize menopause. In my view, the medicalization of menopause and the promotion of HRT for the rest of women's lives stems from a set of social factors including the dominant role of medicine in

defining bodily states, the role of pharmaceutical companies, the media, doctors' training and socialization in a male-dominated field, as well as a culture that values youth. Consequently many doctors prescribe a drug, HRT, for the rest of healthy women's lives, which essentializes women's menopausal bodies as inherently diseased.

The findings illustrate *how* some of these social factors operate together to pressure some women to choose HRT. Within the doctor-patient interaction some doctors persistently initiate discussions about HRT and frame it as a good choice, some use power-laden language that characterizes HRT as a medical necessity while others overstate the benefits of HRT and avoid discussing alternatives. Furthermore, some women describe how family and friends discuss HRT as a net benefit and recommend that they take it as well. The findings provide examples of how some women feel compelled to take HRT because of advice from their doctors, family and friends. Some women feel conflicted about this advice, however, and may be compromising their current quality of life because they believe it will help ensure a healthier life in the future. Possibly some women are increasing their risk for cancer as well. I argue that these findings illustrate the complexity of framing HRT as an individual choice in a cultural, social and medical setting that promotes HRT as a net benefit for women's health. Not all women have the time and resources to research the benefits, risks and alternatives to HRT to decide for themselves what is the best option for their health.

These findings suggest a difference by sexual orientation, however. Fewer lesbians take or have tried HRT, which may reflect their general mistrust of the medical establishment (O'Hanlan, 1995). Also, one interview suggests that lesbians may have resources that frame menopause as a normative event, which may influence them to reject dominant medical constructions of menopause as a disease.

In summary, this study illustrates how culture shapes the biological experience of menopause for the heterosexual and lesbian women in this study. My analysis highlights the role of cultural ideas about menopause and gender, and the importance of sexual orientation, class and race for understanding how menopause is a social experience. This understanding points to cultural ideas and social arrangements that need to be changed to improve women's experiences with menopause and to reclaim it as a natural phase in women's lives.

Social Policy Implications

What can be done to help transform the social meaning of menopause to a normative experience? How can women be better prepared for what to expect during menopause? I have argued throughout this dissertation that women's negative expectations and experiences with menopause, sex, and medical care are shaped by dominant cultural ideas about menopause, gender and heterosexuality and reproduced through social interactions. This argument suggests that these cultural meanings and

social interactions would need transformation to positively influence women's expectations and experiences. How can we undertake such a huge task?

I believe that short of a social revolution in transforming meanings of menopause, gender and heterosexuality, intermediate steps could be taken to reshape women's expectations and inform them about their bodies. First, girls and women (and men) need comprehensive education about menopause and women's bodies. I believe that, like the four women who received positive education about menopause from their mothers, positive education based on menopause as a normal event, although difficult for some women, could replace cultural stories characterizing it as a time of physical, psychological and sexual decline. Systematic school health programs could begin this education for girls.

Adult women would need alternative sources of information, however. My recent experience with pregnancy and birth may provide some ideas. During my pregnancy and stay at the hospital for birth, I was struck by the comprehensive information I received from my health insurance company and hospital about the details of labor, birth, nursing, nutrition, exercise and newborn behavior. Of course, receiving such information on menopause from insurance companies and doctors' offices means that information will be skewed to promote HRT. Therefore, I believe that a consortium of women's health organizations should organize and seek funding to provide comprehensive information to adult women through written materials and community health programs.

Second, along the same lines, research that documents women's experiences with menopause and provides women's narratives needs to become more widely accessible and available. Many women told me throughout the interviews that they wished they could read about what other women experienced so they could know what to expect. For example, one woman said that she conducted her own poll among friends and co-workers to find out how others deal with hot flashes. She said that she wishes she could find a book that shares this information.

Third, as Martin (1996) discusses, girls and women need education about their bodies and sexual desire. They need explicit information on how to recognize sexual desire in their bodies, to identify the parts of their genitals and the role of the clitoris in sexual stimulation, to know why and under what circumstances their genitals become warm and stimulated, and to understand what an orgasm is and what activities give them orgasms (Martin, 1996). Women also need to be educated about how to recognize sexual desire, when they want to act on their desire, as well as when they want to reject sexual propositions. Sex education programs typically emphasize saying no and do not include discussions of when to say yes (Martin, 1996). In terms of menopause, accessible information on how menopausal changes can affect sexual functioning is also needed. Documenting women's experiences with midlife sexuality can inform women about how others view menopausal changes for their sexual functioning as well as how women manage these changes.

This research contains several suggestions for how to improve medical care for menopausal women as well. First, women clearly appreciate the whole person approach to care as opposed to treating bodies like machines with symptoms. Second, women want their doctors to educate them about the physiological process of menopause so that they can know what to expect. Third, women say that they wish their doctors would discuss alternatives to HRT and do not want their doctors to pressure them about HRT. And, fourth, doctors and nurse practitioners could initiate discussions with women about their sexual functioning to provide women an opportunity to discuss these issues if they wish, but feel too embarrassed or uncertain about how to initiate such discussions. In addition, doctors and nurse practitioners should be sensitive to issues of sexual orientation and not assume that women are heterosexual. These assumptions can alienate their lesbian patients.

Finally, this research highlights some problems with our society's institutionalization of heterosexuality. If our society recognized same-sex unions as equally legitimate as heterosexual unions, then lesbians and gays could receive the same material benefits as heterosexuals such as health insurance, tax breaks, and safe retirement homes. In the current conservative political climate, however, such changes seem far-reaching. But, as the baby boomers continue to age, maybe midlife and aging heterosexual and lesbian women will join forces and refuse to be ignored, as one lesbian in my study warns:

> I recognize that there are so many more opportunities for people aging in our society today than there ever were. There are going to be more of us for one

> thing. And I do believe if the wrong people get elected on the federal level and start messing with things like Social Security and Medicare, that we are going to have a revolution and I'm going to be right out there with the rest of them. We know how to do it from the 60s. I think as I age, people my age will be a force to be reckoned with in a way that they haven't been, we will have much more political power than any old group before us.

Perhaps menopausal women full of zest will lead the way toward creating a society that values aging women.

Table 1: Sample Characteristics

NAME	*AGE*	*RACE*	*RLTNSHP.*	*EDU.*	*WORK*	*INCOME*
Janet	52	Caucasian	L/P	H.S.	Lobbyist	>100,000
Margaret	55	Caucasian	H/M	H.S.	Retired	30-35,000
Beth	54	Caucasian	H/M	B.A.	Free lance	>100,000
Angie	51	Afr-Amer	H/Sep.	H.S.	Supervisor	15-20,000
Donna	54	Caucasian	H/M	H.S.	Homemaker	50-60,000
Mary	57	Caucasian	H/M	H.S.	Retired	30-40,000
Sarah	58	Caucasian	H/M	H.S.	Clerical	40-50,000
Carol	71	Caucasian	H/M	M.A.	Retired	10-20,000
Anna	56	Caucasian	H/M	M.A.	Teacher	30-40,000
Susan	58	Caucasian	H/D	M.A.	Therapist	30-40,000
Barbara	55	Caucasian	H/M	M.A.	Fundraiser	>100,000
Chiyo	64	Japanese	H/M	B.A.	Teacher	>100,000
Jane	61	Caucasian	H/M	B.A.	Homemaker	40-50,000
Courtney	60	Afr-Amer	H/D	H.S.	Admin. Asst.	40-50,000
Nancy	60	Caucasian	L/P	H.S.	Nurse	80-90,000
Daphne	60	Caucasian	L/P	Ph.D.	Professor	90-100,000
Sally	56	Caucasian	L/S	H.S.	Disability	<10,000
Pat	64	Afr-Amer	H/Sep.	B.S.	Admin.	10-15,000
Ellen	53	Caucasian	H/M	H.S.	Accounting	70-80,000
Sandy	57	Caucasian	H/M	H.S.	Accounting	70-80,000
Selena	59	Caucasian	L/S	B.A.	Editor	20-30,000
Sophie	55	Native American	L/P	B.A.	Counselor	70-80,000
Sharon	53	Caucasian	H/M	H.S.	Secretary	50-60,000
Marcia	48	Hispanic	L/P	B.S.	Researcher	90-100,000
Brenda	58	Caucasian	L/P	H.S.	Painter	40-50,000
Martha	56	Caucasian	H/D	M.A.	Teacher	40,50,000
Kate	60	Caucasian	L/P	M.A.	Public Affairs	>100,000
Kathy	56	Afr-Amer	L/P	H.S.	Disability	40,50,000
Andrea	49	Afr-Amer	L/P	B.A.	Community Services	50-60,000
Peggy	46	Afr-Amer	H/D	B.S.	Teacher	40-50,000

Relationship: L=Lesbian; H=Heterosexual; P=Partnered; S=Single; D=Divorced; Sep.=Separated

Table 2: Characteristics of Lesbian Women

NAME	*AGE*	*RACE*	*RELTNSHP.*	*EDU.*	*WORK*	*INCOME*
Janet	52	Caucasian	P	H.S.	Lobbyist	>100,000
Nancy	60	Caucasian	P	H.S.	Nurse	80-90,000
Daphne	60	Caucasian	P	Ph.D.	Professor	90-100,000
Sally	56	Caucasian	S	H.S.	Disability	<10,000
Selena	59	Caucasian	S	B.A.	Editor	20-30,000
Sophie	55	Native American	P	B.A.	Counselor	70-80,000
Marcia	48	Hispanic	P	B.S.	Researcher	90-100,000
Brenda	58	Caucasian	P	H.S.	Painter	40-50,000
Kate	60	Caucasian	P	M.A.	Public Affairs	>100,000
Kathy	56	Afr-Amer	P	H.S.	Disability	40-50,000
Andrea	49	Afr-Amer	P	B.A.	Community Services	50-60,000

Relationship: P=Partnered; S=Single

Table 3: Characteristics of Heterosexual Women

NAME	*AGE*	*RACE*	*RELTNSHP.*	*EDU.*	*WORK*	*INCOME*
Margaret	55	Caucasian	M	H.S.	Retired	30-35,000
Beth	54	Caucasian	M	B.A.	Free lance	>100,000
Angie	51	Afr-Amer	Sep.	H.S.	Supervisor	15-20,000
Donna	54	Caucasian	M	H.S.	Homemaker	50-60,000
Mary	57	Caucasian	M	H.S.	Retired	30-40,000
Sarah	58	Caucasian	M	H.S.	Clerical	40-50,000
Carol	71	Caucasian	M	M.A.	Retired	10-20,000
Anna	56	Caucasian	M	M.A.	Teacher	30-40,000
Susan	58	Caucasian	D	M.A.	Therapist	30-40,000
Barbara	55	Caucasian	M	M.A.	Fundraiser	>100,000
Chiyo	64	Japanese	M	B.A.	Teacher	>100,000
Jane	61	Caucasian	M	B.A.	Homemaker	40-50,000
Courtney	60	Afr-Amer	D	H.S.	Admin. Asst.	40-50,000
Pat	64	Afr-Amer	Sep.	B.S.	Admin.	10-15,000
Ellen	53	Caucasian	M	H.S.	Accounting	70-80,000
Sandy	57	Caucasian	M	H.S.	Accounting	70-80,000
Sharon	53	Caucasian	M	H.S.	Secretary	50-60,000
Martha	56	Caucasian	D	M.A.	Teacher	40,50,000
Peggy	46	Afr-Amer	D	B.S.	Teacher	40-50,000

Relationship: D=Divorced; Sep.=Separated

Appendix A:

COVER LETTER

Is She "Past Her Prime" or "Full of Zest?" How Women Negotiate Cultural Expectations About Femininity and Sexuality During Menopause and Mid-Life

You are invited to participate in a study on women's experiences with menopause and mid-life relationships. My name is Julie Winterich and I am a graduate student with the Sociology Department at the University of Texas at Austin. I am carrying out this project to fulfill the requirements of my Doctoral Dissertation. I hope to learn that going through menopause and reaching mid-life is a rich experience and varies from woman-to-woman. You were selected as a possible participant in this study because you have experienced menopause naturally and a friend/colleague of yours gave me your name. You will be one of 30-40 subjects chosen to participate in this study.

If you decide to participate, I will interview you for one to two hours. My interview consists of four groups of questions relating to menopause and mid-life: your general experiences with menopause; your feelings about your appearance and your beauty practices; your mid-life work and personal relationships; and your experiences with your doctor. These issues sometimes cause difficulty for some women. However, most women report that talking about these issues is beneficial to them.

Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission. This interview will be tape-recorded. Your name and any identifying characteristics will be removed from all written records of the tapes and any written reports about the interviews. The tapes will be kept in my locked files.

You are making a decision whether or not to volunteer for this study. Your decision whether or not to participate will not affect your future relations with the University of Texas at Austin. If you decide to participate, you are free to discontinue participation at any time for any reason.

If you have any questions, please ask me. If you have any additional questions later, I, Julie Winterich, 717-258-5581, or my supervising professor, Debra Umberson, 512-471-1122, will be happy to answer them. You may keep a copy of this form.

Appendix B: Question Guide

This is a study on women's experiences with menopause and mid-life. I have five categories of questions. I will ask you questions about your experiences with menopause; how you feel about you appearance; about your relationships at home and at work, and whether you have seen a doctor for menopause. Then I have just a couple of general questions.

I.) Peri-Menopause

1.) Did you have any expectations about menopause before it started? Did you talk to anyone? Your mother? What did she/they say?

2.) How did you know you were going through menopause? What was it like? Was it what you expected? How did you feel about these changes?

3.) How do you feel about being menopausal? Have you ever been pregnant? If so, how do you feel about the fact you can't get pregnant again? If have children: Have your children left home? How do you feel about that?

4.) What else was going on in your life as you went through menopause?

II.) Body Image and Beauty Practices

1.) How would you describe your appearance if I couldn't see you? How do you feel about your appearance? How do you feel about wearing a bathing suit? Examples. (Probe for influence of media images when appropriate).

2.) Has reaching mid-life affected your body/appearance? If so, how do you feel about those changes? Any comments by others?

3.) Do you use or have you used hair color, make-up, electrolysis, plastic surgery and any other appearance altering products? Are any of these new? Do you think about plastic surgery?

III.) Personal Relationships

1.) Did you talk to your friends about menopause? What did they say? Did they give advice about whether to take hormones?

2.) How long have you been with your spouse/partner? How would your partner describe your relationship overall? Do you agree? What about your sexual relationship?

3.) Did your spouse/partner say anything to you about menopause before you started going through it? Did you have any expectations that menopause or mid-life would affect your interest in sex? Has menopause or mid-life affected your relationship, including your sexual relationship?

4.) Have you noticed any changes with interest in sex? Frequency of sex? Vaginal dryness? Orgasms? Do anything for vaginal dryness? Feelings about any/all of this?

5.) Do you think there is a difference between sex and intimacy? Do you feel intimate with your spouse/partner? Can you describe an intimate moment you have shared recently?

IV.) Work

1.) What type of work do you do? Is it the same job you had before menopause?

2.) Did you have hot flashes, mood swings, heavy bleeding at work? What happened? Did anyone say anything to you? Examples.

3.) Has reaching mid-life affected the way you view yourself at work? Do you think others view you differently? (Examples of relationships with men changing in any way.)

4.) Have you ever received unwanted comments by anyone about your body/appearance? (Example). Has this changed since reaching mid-life?

V.) Health

1.) Did you see a doctor about menopause? What did your doctor say?

2.) How do you think this doctor would you describe your overall health? Has anything about your health changed since menopause?

3.) Did you discuss HRT? Do you take HRT? Likes/dislikes? How long plan to take it?

4.) Do you think your doctor has provided good care in terms of menopause? What has your doctor done well? What do you wish he/she did differently?

5.) As you think about the future, what would you say your biggest health concerns are (if any)?

VI.) General Questions

1.) Do you have any older women role models who you look up to?

2.) Do you associate menopause with aging? How do you feel about aging? What are your goals for yourself for your future?

3.) What advice would you give to a younger woman about menopause? What advice would you give about HRT?

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