Panic and Panaceas: Hormone Replacement Therapy and the Menopausal Syndrome

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ABSTRACT

Hormone replacement therapy (HRT) has been touted as the panacea for women's menopausal complaints. This paper examines HRT and the construction of the menopausal syndrome, and the response of Somali, Chinese and Chilean Canadian women to this model of menopause.

RÉSUMÉ

Le traitement hormonal substitutif (THS) a été vendu comme la panacée des plaintes des femmes ménopausées. Cet article étudie le THS et la construction du syndrome de ménopause et la réponse qu'ont les Somaliennes, les Chinoises, les Chiliennes et les Canadiennes à ce modèle de ménopause.

INTRODUCTION

As over 700 million women world-wide have entered the post-reproductive phase of their lives (Diczfalusy 1986), interest in menopause has burgeoned. Maturing women in North America frequently encounter discussions of menopause in the popular media and in their physicians' offices. Informed predominantly by biomedical and psycho-social perspectives, written materials found in bookstores and at pharmacy counters caution women about the dangers of brittle bones, declining estrogen levels and the agony of lost sex drive and youth (ICN n.d.; PAAB n.d.; Sheehy 1992). While much of this literature offers hormone replacement therapy (HRT) as the logical corrective to menopausal complaints, works informed by the self-help industry and alternative health movement focus on herbal and dietary alternatives to achieve similar ends (Northrup 1994; Sander 1991). Both perspectives, however, presume menopause to be a problematic syndrome indicated by somatic and psychological symptoms that inevitably require intervention.

In Western scientific terms, menopause is defined as the permanent cessation of menses, while peri-menopause refers to one year prior to, and one year following the last menstrual period and post-menopause corresponds to the period that follows 12 months of amenorrhea (WHO 1981). These definitions encompass natural and surgical menopause as well as amenorrhea and do not reflect personal or cultural definitions (Kaufert et al. 1986). Lock's (1993) work in Japan has demonstrated that definitions of menopause can vary considerably across cultures and may not be confined to a two-year period or even include the cessation of menses. For the purposes of this paper, the term menopause will be employed as it is in popular discourse to refer to both peri- and post-menopause.

Feminist and anthropological critiques of biomedicine have contributed to a more critical understanding of menopause as a gendered, political-economic and socio-cultural process that is individually experienced and nuanced. In this paper, I will explore the menopausal syndrome and its panacea, HRT. I will begin by providing an overview of the biomedical construction of menopause in North America and its reflections in popular media and medical literature. In addition, I will examine the penetration of the medical model of menopause and HRT use throughout the diverse ranks of menopausal women and discuss the responses of Chilean, Chinese and Somali Canadian women to the prevailing discourse on menopause. I suggest that despite aggressive efforts by pharmaceutical companies and the consent of bio-scientific authorities, the medicalization of menopause remains partial. The process however will neither contract nor remain static, instead the construct of the menopausal syndrome will continue to inform and supplant women's perspectives on the change of life in later years.

CONSTRUCTING THE MENOPAUSAL SYNDROME

In the English-speaking world, the first efforts to medicalize menopause can be traced to Dr. Edward Tilt, a mid-nineteenth century London physician. Tilt's studies in France had brought him into contact with the work of C.P.L. de Gardanne, the French physician who first coined the term menopause to describe a syndrome that was alternatively referred to as "*le temps critique*" or "*l'enfer des femmes*" (Wilbush 1986). These Victorian physicians attributed menopausal complaints either to nervous derangement caused by the violation of gender roles or to a "plethora": the accumulation of toxins normally eliminated as part of the menstrual cycle. The remedy for the latter included bleeding and the administration of emmenagogues. However, nervous derangement was usually remedied with liberal doses of opium (Smith-Rosenberg 1973; Wilbush 1980).

Biomedicine continued to consolidate its status in Europe and North America in the early twentieth century by gaining control of medical education and professional licensing, thereby forging a field of practices that staked claim to scientific authority (Freund and McGuire 1995). Once it came to dominate the healing professions, biomedicine sought areas to expand its markets and women's bodies offered great possibilities. After pregnancy and childbirth increasingly became the domain of biomedical practitioners (Wertz and Wertz 1977), women's post-reproductive years proved to be fertile terrain for potential medicalization.

The discovery of sex hormones, the rise of gynecology, the expansion of the pharmaceutical market and the movement towards greater medicalization coalesced to construct an image of the menopausal body as a degraded and deteriorating entity, one that was crying out for repair. A psycho-social dimension was added by noted Freudians such as Helen Deutsch who insisted that post-menopausal women would fall prey to depression and pathetic displays of desperate sexuality (Deutsch 1945). Thus a menopausal syndrome was predicated upon the discovery of an etiology provided by the emerging field of endocrinology and the remedy offered by the pharmaceutical industry (Bell 1987; Oudshoorn 1994). As the production of synthetic hormones became more cost effective, menopause became more aggressively marketed as a disease (MacPherson 1981).

But what evidence did clinicians have for the growing concern over menopause as a disease? The Medical Women's Federation's (1933) survey of British women in the late 1920s found that ninety percent of those surveyed carried through the menopausal transition without consideration of complaints. Furthermore, numerous studies conducted in the 1940s and 50s debunked the assertions of Freudians that women reputedly suffered great psychological distress at the loss of their reproductive potential (Greenhill 1946; Stern and Prado 1946). Indeed, one psychiatrist complained that patients referred by physicians for involutional melancholia (i.e., menopause-associated depression) were menstruating regularly; he noted, however, that many of these women were married to alcoholic and abusive husbands (Donovan 1951).

In the ensuing years, many studies contributed to inaccurate reporting of symptoms by focusing on clinical populations, conflating current symptoms with previously existing conditions and relying on symptom lists that in reality reflected the cultural construction of menopause (Ballinger 1985; Goodman 1980; Kaufert and Syrotiuk 1981). Epidemiological surveys tempered the findings of the clinical research by demonstrating that most women had relatively positive attitudes regarding menopause regardless of complaints - the rates of which varied with the phase of the menopausal transition (Avis and McKinlay 1991; Kaufert 1980; McKinlay et al. 1992; McKinlay and Jeffreys 1974).

CHANGING SHAPES OF MENOPAUSE

Throughout this period, the constellation of symptoms associated with menopause that comprised the menopausal syndrome also changed. These complaints ranged from digestive and psychological problems in the 1950s to the inclusion of indecision, hair loss and skin changes just a decade later (Mitteness 1983). Current literature, sponsored by pharmaceutical companies and health professional organizations, lists hot flashes, night sweats, decreased libido, vaginal dryness and itching, thinning of the vaginal wall, memory loss, insomnia, decreased bladder control, mood swings, weight gain, changes in skin elasticity, osteoporosis and increased risk of cardiovascular disease (ICN n.d.; PAAB n.d.; SOGC 1996). The relative fluidity of the type and number of symptoms and disease risks associated with menopause allude to the slipperiness of the "facts" and to the continued construction of a syndrome that is thought to require intervention.

ERT/HRT: PANACEA OR PROPHYLAXIS?

Approximately fifty percent of women undergoing the menopausal transition experience some symptoms; however, only a fraction of those women (i.e., twenty percent in the United States) will seek medical advice (Johnson 1998). Most will leave their physician's office with a prescription for estrogen replacement therapy (ERT) or hormone replacement therapy (HRT), a combination of estrogen and progestogens that are recommended for all menopausal

women by groups such as the Society of Obstetricians and Gynecologists of Canada (SOGC) (Sommers 1996).

Interestingly, while most women seek relief from symptoms, medical professionals encourage the use of HRT as a prophylaxis against diseases such as osteoporosis, coronary heart disease (CHD), breast and endometrial cancer and Alzheimer disease (Johnson 1998). Described as a panacea, Ettinger (1988, 31) wrote that "estrogen therapy can alleviate menopause-related sleep disorder, psychological problems, and sexual dysfunction." He later added that, "more than one fourth of estrogen users required a hysterectomy" (33). When estrogen therapy became linked to endometrial cancer and gallbladder disease, its use declined. However, the addition of progesterones to the cocktail of HRT ameliorated some problems while contributing to others. Recent literature suggests that "long-term use (five years or longer) and current use of estrogen as well as combined estrogens and progestogen are accompanied by a slight [sic] but significant increase in risk of breast cancer, of the magnitude of 30-50 percent" (Burger and Kenemans 1998, 43).

To counter a decline in HRT sales precipitated by fears about cancer risk, prevention of both osteoporosis and coronary heart disease were added to the list of benefits of HRT use (Coney 1994). The risks and benefits of long-term ERT/HRT use has yet to be confirmed in randomized control trials; however, proponents feel sufficiently confident to maintain that "for the woman who is of average risk of breast cancer, long-term estrogen use is relatively safe" (Johnson 1998, 306).

ERT/HRT USERS

Epidemiological surveys monitoring HRT use seldom consider sample bias; however, HRT users also tend to be thinner, better educated, and more likely to exercise, take vitamins and consume more alcohol than non-users, all factors that contribute to a reduced risk of CHD (Johnson 1998). In the United States, HRT users are characteristically Euro-American, English speakers and well-educated; those who prolong use of HRT are generally high income earners who place a high value on healthy lifestyle (NAMS 1998). While these factors make the prophylactic claims of HRT with regards to CHD suspect, they warrant little more than a brief mention in some medical literature.

MEDIA AND MENOPAUSE

While risk and gaps in knowledge are downplayed in medical literature on menopause, popular literature found on the pamphlet stands in doctors' offices and pharmacies rarely addresses the question of risk associated with HRT use. Instead, menopause is often portrayed as a natural, although an apparently troublesome, phase in women's lives. Women are told they may notice skin wrinkling, memory loss or irritability (Upjohn n.d.). Exercise, attention to nutrition and hormone replacement therapy are construed as healthy choices and recommended as part of women's self-care regimens (ICN n.d.; PAAB n.d.).

In an inversion of nature and technology, menopausal women's bodies are construed as "un-naturally" devoid of estrogen. Postmenopausal bodies are described as diminished and subject to a host of complaints and disorders ranging from Alzheimer disease, osteoporosis and coronary heart disease to an unsatisfactory sex life and the ravages of old age. As one pamphlet (*What Every Woman Should Know About Menopause*) asserts after stressing that menopause is a natural part of aging, "symptoms may last for 2 or 3 years or more...But there are other problems related to estrogen loss that you can't feel now, and these problems don't go away. They can stay for years and can be very serious." Therefore, to be returned to their natural state, postmenopausal women require the technological replenishment of hormones derived from the urine of pregnant mares, a source that is likewise touted as "natural." Clearly, making the wrong choice and allowing oneself to plummet into an estrogen-deprived post-menopause is portrayed as leading to apparently ominous consequences.

Many of these themes are taken up in the popular literature where menopause is likely to be regarded as a recent phenomenon reflecting confusion between life expectancy - generally depressed by high mortality in early childhood - and life span. Therefore, even in societies where life expectancy did not exceed fifty years of age (the average age of menopause), there were always women who lived years beyond their last menstrual period. While popular literature often provides broader information on alternative remedies and diets that promise to relieve symptoms, including herbal preparations, foods rich in phyto-estrogens, exercise to strengthen bones and dissipate tension, the focus tends to remain on the alleviation of symptoms (Northrup 1994; Sander 1991).

MEDICALIZATION?

The medicalization of menopause has not been as complete as anticipated by biomedical and pharmaceutical proponents (Odens et al. 1992); however, in medical and popular discourse, it has colonized women's bodies and normal lifecycle. This process of medicalization is not neutral, but is inextricably linked to the position of pharmaceutical companies in world capitalism and the function of biomedicine in exercising its power to label, control and

sanction behaviour. The dominance of bio-scientific discourse and its ability to usurp the mantle of truth can have powerful effects on women as subjects. Indeed, Dickson's (1990) study of middle-class Euro-Americans found that their knowledge of menopause and the language they used to describe it were readily displaced by the biomedical perspectives and concepts they encountered. Medical personnel and stakeholders in the menopause industry often measure the success of their endeavours through the use of HRT/ERT, suggesting, as Calaf I Alsina (1997) has, that although women reportedly experience adverse reactions that affect the quality of their lives, a minority of women avail themselves of the therapy because they are yet unaware of its value.

One of the first Canadian surveys to investigate women's attitudes towards menopause and hormone therapy was conducted in Manitoba in the 1980s and revealed that less than 50 percent consulted with their physicians regarding menopause, 15 percent of whom were receiving ERT prescriptions (Kaufert and Gilbert 1986). Has this profile changed in twenty years?

More recent statistics suggest that between 10 and 30 percent of Canadian menopausal women are on hormone replacement therapy (Jolly 1997). Findings from Western Canada suggest that the rate of HRT use has remained stable since Kaufert and Gilbert's 1986 study. Apparently, 15 percent of menopausal women avail themselves of HRT for an average of two years, a period deemed too short to produce potential benefits (Cummings and Cummings 1999). These rates vary somewhat from the European statistics that reported 10 and 20 percent HRT use during that same period, yet suggest that country of origin is a major determinant in the use of HRT (Schneider 1997). Approximately half of women who commence HRT discontinue it within the first year, and 75 to 80 percent will stop taking the therapy within three years (Ettinger, Pressman and Bradley 1998; NAMS 1998). Notably, the average continuance rate for all medications is 75 percent (NAMS 1998). Elaine Jolly, as president of the Society of Obstetricians and Gynecologists of Canada, lamented that third parties such as feminists, the lay press, friends and neighbours remain sources of misinformation and pressure to dissuade women from using HRT or encouraging them to stop (Jolly 1997).

If women are not eager to avail themselves of the biomedical panacea, how are they regarding menopause? Woods and Mitchell's survey of 500 women in Seattle revealed that most defined menopause in terms of affect rather than endocrine changes; in particular, individuals were responding to the post-reproductive phase of their lives (Woods 1999). Moreover, physicians were not regarded as necessary mediators. While this survey was conducted in a culturally diverse neighbourhood, I will briefly examine some ethno-specific responses to the menopausal syndrome based on a Canadian study.

MENOPAUSE IN CROSS-CULTURAL PERSPECTIVE

Until recently, much of the research on menopause has been informed by biomedicine and focused on the expression of symptoms. While predominant menopausal symptoms have been shown to differ cross-culturally from sore shoulders in Japan (Lock 1993), weak eyesight in South Asia (George 1988) to memory loss (Moore 1981) and palpitations (Moore and Koombe 1991) among women in sub-Saharan Africa, the perceptions of these sensations are culturally informed and individually expressed (Beyenne 1989). Moreover, diet may play a significant role in the expression of complaints (Beyenne 1989). Symptoms, however, do not tell the entire story and menopause often has a far wider range of meanings for women than is allowed by a focus on complaints. In an examination of women's experiences of menopause in 96 cultures, it became evident that the presence or absence of menopausal symptoms did not determine whether women had a positive or negative appraisal of menopause (Spitzer 1995). Women who felt satisfied that their childbearing was complete, enjoyed meaningful work, could avail themselves of positive roles or, in the absence of publicly recognized roles, were able to imbue their post-reproductive lives with meaning, generally regarded menopause favourably.

METHODS

To understand if and how women could create or re-create meanings of menopause in a new environment, I interviewed 33 immigrant and refugee women, 11 each from Somalia, China and Chile who had either ceased menstruating or were experiencing changes in their menstrual cycle (Spitzer 1998). Women were recruited for the study via network sampling (snowballing), a technique that is particularly well suited to working in populations that may be difficult to enter (Brink and Wood 1988; Morse 1991). Ethics approval for the study was granted, designating procedures to ensure confidentiality of participants' identities and data.

Interviews, based on a semi-structured interview guide, took place in one or two sessions and ranged between two to six hours in total. They were held in the language of the woman's choice and took place in a setting selected by the informant. To enhance reliability, a single interpreter, if required, was engaged for each language combination. Participation in the study was voluntary and informed consent was either taped or obtained in writing. Interpreters also signed a

confidentiality agreement. Interviews were taped, transcribed and coded using the qualitative research software Q.S.R. NUD-IST. Transcripts were subject to theme and content analyses. The latter were then reviewed by informants (two per community) who verified the interpretation of the data. All names used here are pseudonyms.

MENOPAUSAL SYNDROME: RESPONSES FROM MIGRANT WOMEN

Somali Canadian Women

The Somali Canadian women who participated in this study were part of the recent diaspora spurred by the civil war that erupted in that country in the early 1990s. In Somalia, women had little contact with biomedical practice or any formal health services. In Canada, medical attention was sought for stress-related disorders that were associated with their status as refugees, their separation from family members and their experiences of trauma. Menopause was conceived of as a natural phenomenon, known as *dhaqmo ka bax,* meaning "unlikely to have children." As Raqiya, a 66 year-old mother of nine children said, "you start your own independence." Menopause was in fact regarded as a cherished period in women's lives when they do not need to "see" men if they so chose. Menopause was further regarded as a gift from God; one which women relish as they are continuously *dahir,* or ritually clean, throughout the month, allowing them to engage in Qur'anic study and prayer without interruption. Aisha, a mother of eight in her 70s who resides in Toronto mentioned: "When you get menopause, it's the best time of your life because you won't miss your praying time and you'll be clean all the time. So we are completely happy!"

Few somatic complaints were associated with menopause. Only one woman complained of hemorrhaging while another had heard of a friend who experienced breast pain. A discussion with a pre-menopausal woman in her 40s who expressed concerns about menopausal symptoms suggested that exposure to the dominant discourse on menopause circulating in Canada may influence the perceptions of younger Somali Canadian women.

In Somalia, women who can no longer bear children are considered old; however, old age is a time of veneration by children, grandchildren and community members, a time spent in the company of women friends and a time spent in spiritual pursuit. In Canada, familial groupings have been fragmented and the respect that older women should accrue may not always be available especially from people outside of the Somali community, yet women have found other ways to re-create meanings of menopause through the companionship of other women and their collective engagement in Qur'anic study.

Chinese Canadian Women

Chinese women were familiar with both biomedical and Traditional Chinese Medicine's (TCM) perspectives on menopause, although all but one referred to menopause as *jue jing* (cessation of flow), rather than by the more elaborate term used for the menopausal syndrome that is comprised of hot flashes, irregular heartbeat, sweating, depression, and change in temperament. While women had heard of HRT both in China and in Canada, most preferred to restore their body to balance using TCM as they had throughout their lifetimes. Menopause offered two - not necessarily mutually exclusive - possibilities. First, menopause was considered a part of life that offered opportunities for a second youth. Cora, age 49, said: "I don't have to do it every month, get the pain every month. I can go to swim or go anywhere and I don't think about that or worry about that." In China, menopause was often concomitant with retirement when, particularly in urban areas, women could spend time with friends, take up new hobbies and often continue in their work on a full or part-time basis as a way of prolonging their meaningful contributions to society.

Second, menopause was also associated with a host of symptoms including: hot flashes, heavy bleeding, changes in temperament and emotional lability, sweating, insomnia, body aches, tiredness, decreased libido and vaginal dryness. Notably, the experience and expression of symptoms were often perceived as the embodiment of stress or trauma. Lai Ming recalled her experience with menopausal symptoms that followed the death of her child from diphtheria: "I could not distinguish whether it was menopause or I was too concerned and nervous about anything. Therefore, when I lost my temper, they would say I had menopause. When I experienced hot flashes, I went to the doctor. The doctor confirmed I was having menopause."

Other women who experienced severe symptoms attributed them to political persecution, frustrating encounters with the bureaucracy or stressful familial relations. There was no effort by Chinese informants, even those who were biomedical physicians, to segregate hormone-induced symptoms from the effects of psychosocial stress reflecting TCM's insistence on mind/body unity (Kaptchuk 1983). Women from Hong Kong and Taiwan were more likely to adhere to biomedical explanations while those from China were more influenced by both biomedicine and TCM, reflecting the respective health care policies of these countries. However, nearly all of the women rejected the lack of holism that they perceived as

characteristic of biomedicine.

Chinese women worked towards re-creating meanings of menopause in Canada. Many women struggled to find avenues for their "second youth" although these efforts were hampered by the high cost of extracurricular activities relative to their depressed economic status (Kazemipur and Halli 2000) and the lack of employment opportunities for mature women with no Canadian job experience and poor English skills. Moreover, the meanings of symptoms (as expressions of public and private pain) were not always acknowledged by health professionals or other members of Canadian society. For many respondents, the dreams of a meaningful menopause had not come to fruition, yet some women availed themselves of free English-as-a-Second-Language classes and volunteer opportunities to meet other newcomers and contribute to the community.

Chilean Canadian Women

Chilean respondents were least familiar with traditional healing practices and more apt to be solely dependent upon biomedical treatment. In Chile, menopausal women are regarded as old and asexual. Monica joined family members in Canada in 1990. She recalled: "Men in my country are laughing about the menopausal woman. Because in the office, the woman says, 'Oh, she has the menopause.' 'Oh [the men say], she is a stupid woman!'"

This group also presented the most elaborated symptom list including hot flashes, moodiness, headaches, body aches, tiredness, heavy bleeding, loss of appetite, nausea, changes in skin elasticity, night sweats, insomnia, increasingly poor health, fragile bones, nervous breakdown, vaginal dryness, old age, decrepitude, loss of intellectual functioning and changes to their appearance. Two of the eleven women were taking HRT at the time of the study. Menopausal symptoms, however, were inextricably linked to women's experiences as immigrants who have experienced a loss of homeland due to social and political realities and a decline in socio-economic status. As Esther, a university-educated janitor and mother of three said: "We've been in Canada for twenty years...If we lost a job, we lose the house because we can't pay the mortgage. Will we have to live with our children after that? So, I don't think it's about menopause affecting the women. No, no. That's the way we live because maybe you wake up at night thinking about it, about tomorrow...but I think maybe the media, when they focus on menopause, they only focus into the health, medicine related. They don't focus on what's going on."

Other women echoed Esther's observations and were inclined to resist explanations by physicians that were deemed to reduce, de-contextualize, and de-politicize women's experiences of the change of life. In Canada, Chilean women have tried to push back the boundaries of old age associated with menopause. Many women spoke of re-negotiating their relationships with spouses, refuting notions that menopausal women were asexual and powerless. Additionally, some saw this phase of life as a time for reflection and connection with other women. Lastly, Canadian society was regarded as offering greater employment and social opportunities for middle-aged women than Chilean society.

THE MENOPAUSAL SYNDROME: CONSTRUCTIONS AND RESISTANCES

What does this brief overview suggest about the construction of a menopausal syndrome and the way in which it has been accepted or resisted by Canadian women from diverse cultural backgrounds? Medicalization, as many medical authors lament, continues to be incomplete, as evidenced by the relatively low rate of HRT use over the long-term. Some have suggested that the failure of biomedicine to completely colonize women's experiences of menopause is due to the private nature of the change (Kaufert and Gilbert 1986). Moreover, women continue to insist on endowing menopause with their own perceptions and meaning as evidenced by Woods' (1999) survey in Seattle and the responses of most of my informants who readily altered meanings of menopause when the conditions that provided that context in their homeland was absent in Canada. Thus, when migrant women were isolated from family and friends who would have offered a source of support, status, and role fulfillment in their post-menopausal years, they imbued roles they could continue in Canada with greater meaning. For instance, Somali women actively sought out age-mates to form Qur'anic study circles while Chilean women placed greater importance on work and career. Chinese women who would have anticipated enjoying a "second youth" in their menopausal years often continuing to work, spend time with friends or engage in creative endeavours, rather availed themselves of free educational opportunities in Canada. While the association of symptoms with menopause and familiarity with HRT was correlated with their exposure to biomedicine in their home country, all of them resisted the idea that menopause could be reduced to the expression of symptoms. Moreover, women who did experience menopausal symptoms resisted attempts by health care professionals to measure complaints in terms of hormones and continued to assert their own interpretation of their bodily sensations linking them with their lives as wives, mothers and immigrant women.

But is medicalization as incomplete as the

statistics on HRT suggest? In the past twenty years, there has been an explosion of literature on menopause in books, magazines and the Internet, and the subject has been highlighted in news stories and on talk shows. The private nature of menopause may be eroding within dominant Euro-Canadian society and within the communities of women I spoke with. Discussion in the public arena leaves menopause open to commodification and colonization by the market forces that offer the latest skin care, herbal preparations and "natural" hormone therapies. In fact, while women still struggle to define menopause in their own terms, the focus of attention has been shifted from the meanings of post-reproduction, mid-life and maturation to the expression of bodily symptoms. Thus, in the reputed liberation of menopausal whisperings among women, discussions have become increasingly dominated by the biomedical discourse. In essence, medicalization of menopause cannot be accurately measured via statistics on HRT use. Rather, one needs to consider the preponderance of the biomedical view of menopause within women's thinking and discussion of the topic.

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