Strategies of Control and Resistance: Lay responses to the medicalisation of menopause

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Introduction

> There's a lot of money to be made from telling healthy people they're sick. Some forms of medicalising ordinary life may now be better described as disease mongering: widening the boundaries of treatable illness in order to expand markets for those who sell and deliver treatments.[1]

Over recent years, the pharmaceutical industry's marketing of 'wonder drugs' for conditions previously regarded as falling within the normal range of corporeal experience has livened the debate surrounding the medicalisation of daily life. There is concern that the 'disease mongering' tactics of the industry may distort medication risks, increase the incidence of iatrogenic illness, foster social phobias around common conditions, and displace social constructions of illness with corporate constructions of disease.[2] However, the commercial marketing of 'wonder drugs' is by no means a recent phenomenon. Since the early 1960s, Hormone Replacement Therapy (HRT) has been promoted to mid-life women as a panacea for the short-term symptoms of menopause, and a treatment for the longer-term effects of oestrogen deficiency. The forty-odd years of industry attempts to recast a normal female life stage as one of hormone deficiency disease (akin to diabetes or thyroid disease), provide a unique opportunity to explore the impact of disease promotion strategies on a targeted group of consumers.

The focus of this paper is on the reaction of a group of New Zealand women to the promotion and management of menopause as a disease of oestrogen deficiency. The objective is to demonstrate that lay resistance is an integral aspect of the process of medicalisation. The discussion will adopt a critical-constructivist position to establish that: a) this group of women were active agents in the process of decision-making on the management of menopause; and b) the women's decision-making processes were most influenced by their common sense models of menopause.

A critical-constructivist perspective acknowledges social reality as the product of historical, social and cultural processes, and the meaning-making activity of the individual mind as collectively generated.[3] The focus on the way individuals make sense of their experience of the world emphasises the relationship between social structures and individual experience. The role of power in defining and sustaining dominant knowledge and beliefs is acknowledged as central to this relationship.

The notion of active agents refers to the ability of individuals to determine those practices, actions and strategies they deemed most meaningful or appropriate to their lives.[4] Common sense is defined as a hegemonic view of reality that involves unconscious acceptance of aspects of everyday life as 'normal' and 'natural'.[5] Because common sense embraces the seemingly normal and natural, its meanings tend to be taken for granted and go largely unchallenged. However, as a mode of consciousness, common sense draws on a wide storehouse of often opposing knowledges derived from antecedent ideologies, and so is characterised by its eclectic, disjointed and contradictory qualities.[6]

The role of common sense in relation to menopause is multi-dimensional: it defines an everyday female life experience; it shapes expectations and gives social meaning; it explains and identifies associated phenomena; and it shapes and informs responses to this event. The impact of common sense views of menopause varies in relation to popular acceptance of competing knowledge sources which can be taken-up and accommodated within the common sense knowledge base.

Medicalisation

Social scientists have traditionally viewed medicalisation as a hegemonic process which reshapes lay perceptions of the body as the medical community attempts to create a market for its services.[7] As a process, medicalisation is characterised by redefining as pathological, bodily processes previously regarded as falling within a range of normal. Medical professionals are recognised as the legitimate custodians of specialised knowledge regarding illness diagnosis, treatment and prevention. A specialised vocabulary emerges which, as it becomes incorporated into the vernacular, reconstructs common sense perceptions of bodily events. There is an

accompanying devaluing of lay knowledge, skills and judgement on matters of health and illness, together with an increase in technological intervention, frequently administered from purpose-built institutions which reinforce the power, knowledge and judgement of medical professionals.[8]

The emphasis of the medicalisation critique on asymmetrical power relationships is under scrutiny.[9] The assumption that recasting normal bodily functions as pathological displaces common sense knowledge is under question. Williams and Calnan,[10] for example, argue that empirical research indicates that the hold of modern medicine over contemporary experience has been exaggerated:

> [T]he structure of lay thought and perceptions of modern medicine is complex, subtle and sophisticated, and individuals are not simply passive consumers who are duped by medical technology. Rather, they are critical reflexive agents who are active in the face of modern medicine and technological developments.

Lupton finds the denial of agency problematic, and questions the continued dominance of the regulative view of medicalisation and the derogatory manner in which the term has been used. She argues that the ways in which medical discourses are taken up, negotiated or transformed by the lay population, warrant further examination. Reminding us of Foucault's emphasis on resistance as a fundamental aspect of power, Lupton argues, 'Power is not a possession of particular social groups, but is relational, a strategy which is invested in and transmitted through all social groups'.[11]

The medicalisation of menopause

Attempts by the pharmaceutical industry to medicalise menopause through the promotion of HRT have received considerable criticism.[12] The focus of such critiques is generally on the industry's promotional strategies aimed at educating both lay and medical consumers.[13] Commonly, these strategies take the form of printed and audio-visual material that describes the physiological changes that occur at menopause, and possible short-term and longer-term symptoms. These strategies have been criticised for promoting psycho-social symptoms such as, 'sleepless nights, lack of concentration, [feeling] emotional, mood swings, irritability, anxiety, depression, loss of sexual desire' and so on,[14] in addition to the medically established symptoms of hot flushes, night sweats and vaginal dryness.[15] Accusations of 'creating

anxieties',[16] and 'putting the living fear of guilt into those women who decide not to use HRT',[17] have been levelled at statements such as the following:

> Many people have osteoporosis – *90% of these are postmenopausal women.*[18] Many do not even know they are at risk. In fact, bone loss usually goes unnoticed until a fracture occurs. It is the first seven years after menopause that are crucial – half of a woman's total bone loss occurs at this time, in the early stages of [o]estrogen deficiency.[19]

> More women die of heart disease than all cancers combined. It is the leading cause of death among postmenopausal women. By restoring the body with oestrogen, many studies show that oestrogen replacement cuts the risk of heart disease by one half.[20]

While the promotion of HRT as presented above could be considered as 'disease mongering', it is surprising that the critical response has generally assumed mid-life and older women to be passive, manipulated victims.[21] The findings of a number of recent studies challenge this assumption. For example, a group of New Zealand women avoided 'taking the easier option of handing over responsibility to their doctor and becoming a passive recipient of the decision made'.[22] Hunter, O'Dea and Britten found that among a group of British woman the decision to take HRT was primarily influenced by immediate and/or relatively short-term issues, rather than by the benefits of longer-term health promotion.[23] They also found that women who experienced mild symptoms were reluctant to take medication because they regarded HRT as inappropriate for the management of a 'natural' process. Similarly, Griffiths found British women reluctant to go on HRT, 'except as a last resort'.[24] Although many sought their doctor's advice on the management of menopause, most made the decision to not take medication on their own. Griffiths' conclusion that women themselves are limiting the medicalisation of menopause, runs counter to earlier critiques of the promotion of HRT. In another study of a group of Welsh women,[25] it was reported that participants accepted only those aspects of the medical explanation of the menopause that were consistent with their established beliefs.

Study Context

The findings presented in this paper are taken from a study of a group of New Zealand women of European descent, conducted in

1995 and 1996.[26] One aim of the study was to explore the impact of the promotion of the deficiency disease model of menopause on the participants' perceptions, understanding and experience of this life stage.[27]

In retrospect, the timing of the data collection was significant. Although the women were exposed to competing discourses on menopause and its management, their responses were not influenced by three key developments. First, the sudden termination (in 2002) of the Women's Health Initiative Longitudinal Study in the United States of America. This study identified a heightened risk of breast cancer, heart disease, stroke and pulmonary embolism associated with extended use of HRT among healthy women.[28] Second, the introduction of direct-to-consumer advertising of prescribed medications in New Zealand in 1996.[29] And third, the impact of the internet as a popular source of medical information, and direct-to-consumer sales of prescription medicines. Not one woman in this study identified the internet as a source of information on menopause

Traditionally New Zealand women have experienced menopause as a private event, surrounded by social taboo.[30] During the 1980s, the topic of menopause, its symptoms and management gradually entered the public arena. This debate was characterised by tensions between the medical definition of menopause as a state of oestrogen deficiency and the common sense perception of this event as a normal, natural part of women's reproductive lives. A Replay Radio[31] production of edited highlights of a talk-back show recorded in 1988 presented women's descriptions of their experiences of menopause and its management. The programme also included advice and information on HRT from a medical specialist. In the early 1990s, the Department of Health produced a series of pamphlets promoting life style changes such as diet and exercise for the control of menopause-related symptoms and prevention of osteoporosis.[32] Around the same time, two educational videos and several audio-tapes produced by pharmaceutical companies became available through general practice surgeries.[33] In 1991, publication of *The Menopause Industry*[34] drew attention to the accusation that pharmaceutical companies were commodifying women's bodies through the promotion of HRT. Shortly after, the Women's Health Action Alliance in Auckland initiated a series of one-day workshops to educate mid-life women on the risks of HRT, and inform them of alternative strategies of symptom

management. Around the same period, the New Zealand Family Planning Association established workshops to promote menopause as a normal, natural life stage. The aim was to empower mid-life women to take control of this event through being appropriately informed and supported.[35] Contrary views on HRT and its benefits were also promoted by public figures such as Sharon Crosbie, Chief Executive of Public Radio in 1996.[36] In that same year Crosby adjudicated the first public meeting of the newly formed New Zealand branch of the Australian Menopause Society at the Wellington Town Hall concert chamber. This event, attended by approximately 200 women, was promoted by the Society as an opportunity for local women to find out about menopause. The format involved presentations from four medical experts on the physiology and medical management of menopause, followed by questions from the audience.[37]

Despite such developments, little research was published on New Zealand women's knowledge and experience of menopause during the 1990s, with no direct information on the trends and prevalence of the use of HRT available until the new millennium. Pharmaceutical records suggest a steady increase in HRT use between 1992 and 1995, during which time prescriptions nearly doubled.[38] Two population-based surveys on the use of HRT among New Zealand women aged between 45-64 years were conducted in 1991 and 1997 respectively.[39] The results, published in 2001, identified an increase in the use of HRT from 12 per cent in 1991 to 20 per cent in 1997 across all socio-economic and educational groups. Both surveys found that most women started HRT for the relief of symptoms, although the prevention of osteoporosis was also a major reason for starting the medication. The authors also noted a marked increase in the 1997 survey (from 13 per cent to 25 per cent) in women taking HRT to prevent coronary heart disease.

Method

The current study adopted an inductive approach to data collection. Rather than attempting to test a hypothesis, this approach seeks to identify broad generalisations as a means of data testing and theory generation.[40] This technique allows participants to identify and explore those aspects of everyday experience they view as most meaningful.

The participants

Although the study recruited a total of 73 participants, the data for this paper is drawn from the responses of the 52 women aged between 42 and 81 years who defined themselves as 'in' or 'through' menopause. Twenty-four of these participants were residents of the prime research site, the Manawatu district of the lower North Island of New Zealand. These women were contacted through local social organisations and by word of mouth or the snowballing technique. The remaining 28 responded to an advertisement placed in the national women's magazine, *New Zealand Women's Day* (*NZWD*).[41] These respondents were drawn equally from provincial/rural[42] and urban areas throughout the country. The data analysis identified no discernable differences between the two groups of participants in terms of the range of expectations, attitudes, perceptions and experiences of menopause identified.

Participant recruitment involved the non-probability technique of self-selected, purposeful sampling. The advantage of this technique was that it targeted women whose interest in the research motivated them to provide rich data. Conversely, a limitation of self-selection recruitment is that while it allows comparisons to be made within and between groups of participants, any findings remain specific to the identified groupings and cannot be generalised to the wider population. This methodological limitation is consistent with qualitative inquiry where the emphasis is on discovering underlying meanings and patterns of relationships, rather than 'numerical representation and manipulation of observations for the purpose of describing and explaining phenomena that those observations reflect'.[43]

A further advantage of the snowballing technique is that because participant recruitment is made through referral from existing informants, it follows the pattern of social relations in a particular setting.[44] As the data collection progressed, recognition of the close social links between many of the Manawatu participants prompted the decision to compare their views and experiences with those of women residing in other areas of New Zealand. This objective was the rationale for the inclusion of the *NZWD* participants, as it allowed for data triangulation. That is, the opportunity to compare data generated from two different purposive samples, each employing different collection techniques.[45]

Participant characteristics

Table 1. Key characteristics of participants who defined themselves as being 'in' or 'through' menopause.

Characteristic	Feilding/Manawatu (N=24)	%	*NZWD* (N=28)	%
Age				
60 years +	(11)	45.8	(2)	7.1
50–59 years	(10)	41.7	(13)	46.4
40–49 years	(3)	12.5	(13)	46.4
No formal education	(10)	41.7	(8)	28.5
Occupation				
Professional	(6)	25.0	(6)	21.4
Self-employed	(3)	12.5	(5)	17.9
Admin/clerical	(1)	4.2	(9)	32.1
Semi-skilled	(3)	12.5	(4)	14.3
Housewife	(9)	37.5	(1)	3.6
Retired	(2)	8.3	(3)	10.7
Has used HRT	(14)	58.3	(18)	64.3

The key characteristics of the two groups of participants are compared in Table 1. Two aspects should be noted. First, formal education was defined as having passed or achieved a level equivalent to or above the New Zealand School Certificate examination. Formerly, this examination was taken around the age of 15 years on completion of three years at secondary school. Aside from the oldest woman in the study (aged 81 years), who left school at age 12, those with no formal education had left school between the ages of 14 and 15, and had not undertaken any further educational or vocational training. And second, in relation to employment among those classified as having a professional occupation, all but one (a medical laboratory technician) were nurses or teachers. The administration/clerical category includes those employed as office managers, bank employees and administrative assistants. Those classified as self-employed were generally engaged in small businesses such as shop keeping and the provision of services (for example, dressmaking), although two in this

category described themselves as a 'farmer' and 'writer', respectively. Three of the five who described themselves as 'retired' had been either a nurse or teacher.

The larger number of Manawatu participants who had no formal education and classified themselves as 'housewives' was associated with the older research population and the fact that very few of the farming women were involved in paid employment. In contrast, the greater number of *NZWD* respondents employed in administrative/ secretarial work appears to reflect better employment opportunities for urban women. Finally, the greater number of *NZWD* respondents aged in their forties seems a disproportionately large group when compared with the Manawatu participants. The reason for this distortion is not clear and may well be a factor of the wider *NZWD* catchment area where a greater number of women were experiencing early menopause.

While there are obvious similarities between the two groups, some differences are apparent in the 'age', formal education and 'occupation' categories. The larger number of participants from the Manawatu area aged 60 years and over, reflects both the nature of the prime research site and the effectiveness of the recruitment techniques employed. Initial contact with potential participants was made through a number of Feilding social organisations, many of which had an ageing membership. At the time of interviewing, the town of Feilding – with a population of around 14,000 people[46] – supported 238 listed social organisations, a phenomenon that appeared to reflect the town's role as both the centre of a large rural community and as a retirement area.[47]

Data collection and analysis

The data collection commenced with a series of six focus groups followed by in-depth interviews among the Manawatu participants. An average of five participants attended each of the focus group meetings which were generally around two-and-a-half hours duration. These groups were facilitated and recorded by the researcher.

In response to the lack of comparative research on the experience of menopause among New Zealand women, the purpose of the focus groups was to identify key issues and themes to be explored through in-depth interviews.[48] At each meeting it was only necessary to pose the question, 'What do you know about menopause?' to initiate the

discussion. From that point onward, little if any facilitation was required until the discussion drew to a natural close. Data saturation occurred around the fourth meeting.

Most of the in-depth interviews were held at the participant's home and ran for between one and two and a half hours. Each interview was tape-recorded and began with the participant completing a brief demographic profile. They were then asked to describe what they knew about the physiological process of menopause and the source of their knowledge, followed by their expectations and experience. Most interviews were participant-led with probing kept to a minimum. Brief notes were taken to ensure the participant covered key issues raised by the focus group members and were followed up if necessary with open-ended questions. Most spontaneously addressed the themes identified by the focus group interviews.

Thirty-two of the forty-seven *NZWD* readers who requested information about the study[49] submitted written narratives in response to a guide sheet. In addition to requesting the same demographic details collected from the Manawatu women, these respondents were provided with a list of open-ended questions designed to guide their narratives. While this technique promoted a more structured approach than in-depth interviewing, the questions addressed the same issues and themes raised by the focus groups and explored during the in-depth interviews. In an attempt to minimise influencing the women's responses, the information sheet emphasised that the questions were intended as a guide only and encouraged respondents to write about those aspects of their experience they considered most significant. Most replies adhered closely to the guide sheet questions. The quality of the responses varied from brief comments noted on the guide sheet itself, to lengthy written narratives.

An unanticipated consequence of the data collection techniques was that they provided a forum through which the women could freely discuss a subject most perceived as socially taboo. Some also indicated their willingness to participate reflected personal frustration over the lack of access to 'satisfactory' non-medical, experiential knowledge. These women hoped their stories would become available to help inform others. While it is difficult to assess the effect of these motivations on the data collected, it needs to be acknowledged that the social orientation of the research may have attracted more articulate participants who held strong and/or atypical views on menopause,

and were more likely to express resistance to the medicalisation of this event.

The focus groups and in-depth interviews were tape-recorded and transcribed, and together with the *NZWD* responses, compiled into individual narratives in preparation for a standard inductive, thematic analysis. The analysis involved compiling data sets of relevant extracts from the transcripts and narratives under each of the focus group-identified issues and themes. At this point, no discernable differences – aside from those related to the women's age group distributions – were evident between the range of expectations, attitudes, perceptions and experiences identified by each group. The themes were further refined into sub-categories by grouping the range of attitudes and views, and diversity of experiences according to age distribution, in preparation for a cross-case, comparative analysis of the responses.

Ethics

Ethics approval for the study was obtained from the Massey University Human Ethics Committee. The prime ethical consideration was the issue of confidentiality, although the majority of participants wished to be identified by their first name. All participants were given written information on the study and provided written consent.

Taboo and stoicism

The climate of taboo

The women's experience of menopause occurred within a social context of taboo and stoicism. The impact of the taboo surrounding social discussion of menopause was strongest among the older women, who typically reported they 'never talked about things like that. Possibly wanted to, but couldn't talk about menopause' (Joan, aged 73, Manawatu). One of the most significant aspects of the taboo was that it inhibited mother-daughter communication, with most reporting their mothers refused to talk about menopause. For some, even broaching the subject with their mother was 'unthinkable'. Typically those who had attempted a discussion described it as 'whispered', superficial and characterised by euphemisms. Only four had talked openly with their mother about her experience.

Despite the women's reluctance to raise the subject with their mothers or peers, some like Marion (aged 65, Manawatu), acknowledged they could talk more freely 'with the younger ones'.

Although a number of the younger women such as Margaret (aged 50, Christchurch) reported 'women rarely talk about menopause', their comments also suggested the taboo was starting to breakdown. Sally (aged 51, Auckland), for example, indicated she 'made a point of raising the subject with friends [so] those who have not gone through it … may be prepared for whatever symptoms they should experience'. Janice (aged 48, Manawatu) had also 'spoken to lots of friends and acquaintances'. Others referred to light-hearted banter associated with any mention of menopause in the workplace, and comments like 'when you are hot, you are hot!' being levelled when a colleague was perceived as experiencing a hot flush (Bobbie, aged 48, Manawatu).

The most significant implication of the taboo surrounding social discussion of menopause was that it restricted the women's access to first-hand, experiential knowledge. Among the older women in particular, many recalled how they approached this event with trepidation because although they were unsure about what to expect, they were well aware of the range of negative stereotypes surrounding 'the change'. Informed by normative definitions of the feminine and the status and role of women in society, these negative stereotypes caricatured the manner in which the end of a woman's reproductive functioning was socially perceived and articulated.[50] For example, many were aware of whispered comments associating 'the change' with local women 'going potty', 'shop lifting', 'being sent down "the mental" for a rest' and, in one case, the tragic suicide of a friend's mother. Others had witnessed aunts and grandmothers being subjected to essentialist jokes and 'put-down' from male relatives in reaction to perceived bodily and behavioural changes. A further source of fear lay with vague childhood memories of female relatives or friends acting strangely. Marion (aged 65, Manawatu), for example, recalled her alarm when an aunt would 'suddenly go puce … wave her arms about and say, "Oh it's the change of life"', even though at the time she had no idea of what her aunt was referring to. Others associated menopause with women taking to their bed for prolonged periods, being irritable and 'very strict', flooding, and so on.

The women's difficulty in accessing common sense, experiential knowledge was compounded by a general dissatisfaction over alternative sources of information.[51] Women's magazines, for example, were a popular source of information across the age groups,

even though many regarded them as unreliable, describing their articles as 'emotive', 'flimsy', and 'sensationalist'. For the older women, magazines were particularly important as they provided a forum where the socially unmentionable could be addressed, and allowed them private access to personal accounts of the experience of others.

Despite being better informed than many of the older women, those in the two younger age groups were the most disgruntled over the quality of available information. The majority had sought medical literature from doctor's surgeries and libraries, and a couple had attended educational workshops. Typically, they described much of the material accessed as 'too technical', or not providing the type of information they sought. Catherine (aged 48, Manawatu), for example, commented, 'I would love to know about my body. Even though you might see pieces of paper [explaining menopause] I still don't understand … what oestrogen is'. Others like Rosie (aged 46, Christchurch), expressed frustration over feeling

> … uneducated about my experience of menopause. As a 'baby boomer' I have always found information on most parts of my life to be accessible but I found information on menopause difficult, especially with answers to my questions.

The tradition of stoicism

Accompanying the climate of taboo was the ethic of stoicism. Grounded in the common sense belief that menopause was a normal, natural life stage, the ethic of stoicism promoted the view that symptoms were all in the mind and best overcome by hard work and a positive attitude. Most affected were the women aged sixty and over. Commonly, these women expressed considerable satisfaction over their ability to 'just get on with it' through keeping busy and not 'dwelling' on discomforts such as hot flushes and night sweats. Among the few who reported bothersome symptoms, menopause proved a difficult event. These were women who reached menopause at a time when their doctors were reluctant to prescribe HRT for symptom management. Betty (aged 69, Manawatu), for example, who entered menopause around 1974, recalled her doctor telling her 'not to worry …. It's all in the mind … [symptoms are] old wives tales!' Following a lecture on her 'fortunate' circumstances – 'a lovely husband, two beautiful kids and no financial worries' – she was prescribed Librium and Valium

for her 'problems'.[52] Dulcie (aged 78, Rotorua), who experienced severe flushes and night sweats, described how she 'grieved' over not being offered HRT by her doctor, and had little choice other than to carry on as best she could, noting, 'there was no scientific things in those days'. Likewise, Beth (aged 71, Manawatu), who eventually gained relief from HRT for severe night sweats, bladder problems and depression, recalled being ostracised by friends who considered her as constantly in 'one of her moods' and lacking 'backbone'. For these women, the ethic of stoicism meant little sympathy from family and friends. By allowing menopause to 'rule their lives' they were considered neurotic. Because their behaviour 'let the side down' they were shunned as deviant.[53]

In contrast with the tradition of taboo, the ethic of stoicism remained steadfast. Manifest through a common desire to control the menopausal body, the ethic of stoicism took on new forms and contradictory positions in response to the promotion of HRT. On the one hand, the use of HRT facilitated a form of pseudo-stoicism through allowing women like Beth to socially conform by appearing to 'just get on with it'. On the other hand, feminist accusations of the commodification of women's bodies through the promotion of HRT,[54] advanced a new orthodoxy. Just as in the past women who articulated their problems were perceived as neurotic and deviant, now those who sought HRT were accused as weak for being unable tolerate unpleasant symptoms, and gullible for allowing themselves to be manipulated by the medical profession. Finally, social reaction to the use of 'unnatural substances' in the body associated with the promotion of HRT spawned a 'radical stoicism'. Most evident among the women aged in their forties and early fifties, the defining feature of radical stoicism was that it reflected the women's ability to act as self-determining agents. Less influenced than their older sisters by the constraints of the climate of taboo, these women were better informed and chose to negotiate menopause 'naturally' by employing self-managed strategies involving diet, exercise and herbal supplements.

Knowledge of menopause

The common sense view of menopause as a normal, natural life stage was taken for granted by the women. Typically they referred to this event in terms of 'just a stage, a natural part of your life' Colleen

(aged 54, Manawatu); 'part of life', Moira (aged 59, Auckland); 'a normal part of life', Sylvia (aged 65, Matamata). A few, such as Beverley (aged 54, Auckland), even articulated how this event *should* be defined, 'Menopause should be promoted as a natural process, not a disease!' While the pervasive influence of the traditions of taboo and stoicism were evident in Jacky's (aged 55, Manawatu) comments:

> In my thirties and forties … [menopause] didn't seem to concern me, even though it was going to happen. I didn't know a great deal about it … just that you had changes in how you felt. I just thought your periods stopped and that was that. I just knew it was going to come and that I was going to be able to cope with this because I had an idea that sometimes these things were a mental attitude.

In common with Jacky, most of the women (with the exception of those with a nursing background) were vague about the physiological changes that occur at menopause, aside from the cessation of menstruation. When asked to describe the changes, most responded with comments such as: 'your hormones change', 'certain hormones are no longer being produced', or 'hormones going haywire for a while'. Although a number of the younger women, such as Pamela (aged 50, Taranaki), were aware of the link between menopause and the decline in ovarian functioning. 'All I know about the physical process of menopause is that the ovaries gradually stop making eggs and oestrogen … the lack of oestrogen in the body causes these symptoms'.

Despite lacking specific knowledge about many aspects of their reproductive functioning, the women's comments revealed an appreciation of the role of 'hormones' in the body. The term was frequently employed, particularly among the younger women, to articulate and account for a variety of physical and emotional experience associated with female sexuality and reproductive functioning. Although very few could explain what a 'hormone' was, they displayed a shared understanding of the meaning of the term.[55]

Meanings of menopause

Ageing

Integral to the women's recognition of menopause as a normal, natural life stage, was their association of this event with mid-life and ageing. The significance of this association varied. For some, such as Colleen (aged 54, Manawatu), and Jackie (aged 61, Manawatu) respectively,

menopause represented 'just a stage, a natural part of your life' which 'also signifies ageing'. Others viewed menopause as a physiological marker. 'You get to the gate of menopause and you go through it and you are an old woman' (Jacky, aged 55, Manawatu). Typically younger women like Anslie (aged 47, Manawatu), who experienced an early menopause, indicated they had assumed this event only occurred in much older women. 'I didn't think I was old enough [and] kept thinking this isn't for me at this stage!'

Health risk

Many of the older women in particular associated menopause with the risk of health problems. Norma (aged 63, Manawatu), for example, felt 'women of a certain age [were] very emotional' and vulnerable to 'breakdowns'; Noeline (aged 61, Manawatu) was aware of acquaintances 'who through the menopausal time … had … a nervous breakdown or anxiety attacks [and needed] to have time out and be helped in those areas'. In contrast, Judy (aged 56, Manawatu), upset by the recent death from ovarian cancer of a close friend who assumed her problems were menopause-related, warned against 'blam[ing] everything on menopause … it has to be proven that it is menopause before they put a label on it!'

Despite many perceiving menopause as a time of health risk, very few reported serious health problems during this time, with most acknowledging that their worst fears went unrealised. Some reported similar experiences to Megan (aged 49, Taupo), who wrote of her newfound sense of 'confidence and well-being' that left her 'less inclined to be buffered by society'. In a similar vein, others noted that the association between menopause, ageing and health risk had motivated them to improve their diet and undertake regular exercise, and they now enjoyed feeling fitter and healthier than when they were younger.

End of fertility

Endorsing the women's association of menopause with ageing and ill health was the evolutionary explanation of this event. The notion that menopause was unique among primates because 'the human female … outlives her reproductive span'[56] made good sense to some, as it confirmed their common sense association of menopause with ageing. Jackie (aged 61, Manawatu) explained:

> … it is only over the last century … that women have lived to an age of being able to go through menopause anyway. Historically speaking most had died by the time they had reached forty! I [have] read that women … started childbirth probably when they were about fourteen or fifteen and by the time they were thirty they were like old hags. They were worn out!

However, not all of the women were convinced by the logic of the evolutionary view. Beth (aged 71, Manawatu), for example, challenged the essentialist assumptions of the argument with the rhetorical question: 'Do you think that perhaps when we get too old to have children, too old to bring them up, too tired or whatever, that we were *meant* to die?

Symptoms

Compounding the link between menopause and health risk, was the wide range of symptoms the women associated with this event. In addition to the medically established symptoms of hot flushes, night sweats and vaginal dryness, a further 28 somatic, emotional and psychological states were attributed to menopause.

Informing the association of depression, anxiety, mood swings, panic attacks, unreliable memory and irritability with menopause (particularly among the older women) was the proliferation of negative stereotypes surrounding the menopausal woman. However, the list of identified symptoms extended well beyond these common sense indicators to include events such as prickly skin, vivid dreams, shyness, acne, palpitations, loss of libido, stress, headaches, aching joints, and so on. A notable feature was that the younger women associated a much wider range of symptoms with menopause – a total of 31 compared with the 14 identified by the women aged sixty and over.

Strategies of symptom management

The desire to control the menopausal body fostered by the traditions of taboo and stoicism was central to the women's experience. Although the impact of the ethic of stoicism emerged as the driving factor behind the women's choice of management strategies, the dominant mechanism of control varied across the three age bands.

Stoicism

As the group most influenced by the social traditions of taboo and stoicism, the 13 women aged over sixty regarded the experience of symptoms as private and best managed by 'getting on with it' through 'hard work' and a 'positive attitude'. For two of the oldest women, these stoic strategies dominated their recollections. Mary (aged 81, Manawatu), emphasised how she was 'too busy working on the farm' to remember much aside from 'the odd hot flush'. Joan (aged 73, Manawatu), used her activities as a nurse at Dannevirke Hospital as the benchmark for her recollections. Aside from a 'big bleed' at the start of menopause and an increase in weight, she admitted she didn't recall 'any trouble' at all.

The most commonly reported symptoms among this group were hot flushes and night sweats. Although most admitted they found these symptoms unpleasant and even exhausting, they were determined not to make a social spectacle of their discomfort. Helen (aged 62, Manawatu), for example, explained how, at the onset of a hot flush, she would 'quietly stand up' or move around in her chair waiting for the sensation to pass. Marion (aged 65, Manawatu) and Jackie (aged 61, Manawatu), both of whom continued to experience flushes and night sweats, associated these occurrences with certain foods, and had modified their diets accordingly. A few reported 'feeling uptight' or experiencing 'anxiety attacks', in addition to tiredness, headaches and weight gain, all of which they regarded as a nuisance best managed through 'keeping busy' and 'not dwelling on it'. As discussed earlier, the two women most severely affected by symptoms (Beth aged 71, Manawatu) and Dulcie (aged 78, Rotorua) experienced social censure over their inability to conceal their discomfort. Only Beth, who entered menopause approximately 13 years later than Dulcie, achieved symptom relief and social conformity when she was eventually prescribed HRT.

In addition to Beth, four other women aged over sixty were on HRT. One had taken the medication for many years, following the removal of her ovaries in her mid twenties. Of the remaining three, two reported unsuccessful attempts to discontinue the medication. Noeline (aged, 61, Manawatu), for example, acknowledged that 'If I could do without [it] I would,' but had found that whenever she tried to wean herself off, her headaches and hot flushes returned within a few days. The third woman remained on HRT on the recommendation of her doctor.

HRT

In contrast with the oldest age group, just under two-thirds of those aged in their fifties had been prescribed HRT, with half remaining on longer-term treatment. This trend identified HRT as the dominant mechanism of symptom control among these 23 women.

Although most approached menopause with the common sense expectation that they should 'just get on with it', many recognised the social requirement of stoic endurance of unpleasant symptoms could effectively be achieved through taking HRT. Those who reported bothersome symptoms admitted they 'could not cope' without the medication. Annette (aged 54, Manawatu), for example, who had been on the HRT for six years:

> … found that … depression, wakefulness, hot flushes were all bothering me and [I have] quite a stressful job [as a secondary school teacher] … and my doctor didn't hesitate to suggest HRT. I did try to come off at one stage and the symptoms reoccurred immediately.

Likewise, Sally (aged 51, Auckland) and Moria (aged 59, Auckland), who held responsible positions as a personal assistant and hospital service manager respectively, also emphasised how their symptoms interfered with their ability to effectively function in the workplace. Sally recalled how prior to going on HRT, she:

> … couldn't remember instructions given to me only minutes before [and] this happened on a regular basis … I also felt very irritable and found myself snapping at work colleagues and friends. I could not understand why I was acting this way. I felt totally out of control. A frightening experience!

Moria, had unsuccessfully attempted to control hot flushes and irritability with herbal preparations before being prescribed HRT five years earlier. Following the return of 'unbearable' hot flushes associated with a recent attempt to slowly withdraw from the medication, Moria wrote, 'I am pleased to say that [I am] back on HRT and life is normal again'.

In common with Annette, Sally and Moira, the majority reported they went on HRT reluctantly and most had attempted to come off the medication. As Colleen (aged 50, Hokitika), explained. 'I don't like taking pills of any sort and yet I found I had to take [HRT] to get relief. I have tried to do without HRT but found I couldn't cope with all the symptoms returning'. Colleen's comments also drew

attention to the women's unease over possible side-effects of the treatment. Many identified their preference for 'natural' strategies of symptom management such as dietary supplements, but had found them to be ineffective. In contrast, Judy (aged 56, Manawatu) held no such misgivings. Labelling HRT a 'miracle pill', she emphasised how she felt 'so well' and attributed the youthfulness and fitness she observed among a number of older women to the medication: 'It is good to know that we can be helped because I think back 20, 30 or 40 years. Those poor women, they aged so quickly and they didn't have this help that we have….'

A dislike of taking 'pills' and concern over possible side-effects motivated three of the women to discontinue the medication in favour of alternative strategies of symptom management. Joyce (aged 57 Manawatu), decided to 'learn to cope' with her hot flushes and make some dietary changes after six months on the treatment. Jan (aged 56, Taupo), who discontinued after eight months:

> … took control of my own strategies [of symptom management]. HRT did not work for me because it is passive … I decided to help myself. I joined the gym and have a weight lifting and exercise programme which I do four or five times a week. I walk as much as possible … I swim whenever I can and love it! [I have] altered my eating habits … and now feel so much better and more confident. A change to reflexology and homeopathy has also played a big part in my well-being.

Marie (aged 50, Nelson), also switched to homeopathic symptom management after five months. She was enthusiastic about the result 'Now that I have found homeopathy I wouldn't touch HRT. There are no side-effects, it is non evasive, no pills to take. Better quality of life than before, because HRT does not address or enhance your life all around.'

The eight women aged in their fifties who had never been treated with HRT, reported a variety of symptoms and coping strategies. Their decision not to take HRT reflected their view of menopause as a 'natural process', a dislike of taking drugs and concern over possible side-effects, particularly breast cancer.[57] Commonly, these women employed a combination of stoic and 'natural' strategies to control any symptoms, which some described as mild. These strategies ranged from the traditional 'positive attitude' to dietary modification and exercise programmes, often in combination with herbal and/or homeopathic remedies.

Natural strategies

Continuing the trend of some of the older group, four of the 16 women aged in their forties resolved not to go on HRT. Although the remainder had all tried HRT, half discontinued the medication in favour of 'natural' strategies. With almost 10 out of the 16 in this age group opting for alternative strategies of symptom management, 'natural' strategies emerged as the dominant mechanism of symptom control among the women in their forties.

The four who resolved not to go on HRT were Monique (aged, 48, Rangiora), Kath (aged, aged 48, Hamilton), Rosie (aged 45, Christchurch) and Lois (aged 49, Auckland). Monique described her strategy for managing hot flushes, panic attacks, mood swings, memory loss and irritability as 'a strange mental outlook and the odd prayer'. Kath, unconvinced 'enough is known about what happens after ten to fifteen years' use of HRT, didn't want 'a bleed each month indefinitely'. She turned down her doctor's offer of HRT for 'bouts of flushes and night sweats' in favour of a regime of dietary modification and exercise. Rosie was 'not keen on yet another drug to keep women right', and together with Kath, opted for an exercise programme. Lois's reluctance to go on the medication sprang from an earlier scare with a deep vein thrombosis.

An overriding concern of the six women who discontinued HRT was their unease over ingesting 'unnatural substances'. Sue (aged, 48, Papamoa) wrote she 'disliked the thought of chemicals' in her body and was aghast that she 'needed to start a period again when my body was telling me I had finished'. Rosie (aged 48, Darfield) 'couldn't imagine being on [HRT] for the rest of my life'. Worried over the long-term side-effects, she turned to homeopathic and herbal strategies to manage any symptoms, although occasionally used HRT patches to alleviate vaginal dryness. Ainslie (aged 47, Manawatu), dissatisfied over a substantial gain in weight while on HRT also found herbal preparations effectively controlled her debilitating night sweats. Ruth concluded that the mildness of her symptoms made HRT 'unnecessary'.

In contrast, the remaining women felt the ability of HRT to effectively alleviate their unpleasant symptoms outweighed their concerns over possible side-effects. Only Catherine (aged 48, Manawatu) discontinued the treatment after 18 months but went back on the medication because her symptoms returned with a vengeance.

Although reassured by her doctor over the long-term safety of the treatment, she regretted being unable to negotiate menopause 'naturally'.

Discussion

Dominating the women's experience and perceptions of menopause was the climate of taboo and ethic of stoicism. The tradition of taboo, while diminishing, continued to restrict the women's access to experiential common sense knowledge. It also fostered the view of menopause as a normal, natural life stage and the proliferation of negative stereotypes about the mid-life woman. The legacy of taboo remained evident through the women's reluctance to broach the subject with their mothers or freely discuss it among friends. Their inability to share experienced-generated knowledge left many uncertain over what to expect at menopause. Although most had gleaned some information from a mishmash of sources that included popular magazines, library books, medical pamphlets, whispered gossip, childhood memories and negative stereotypes surrounding the menopausal woman, most expressed dissatisfaction with these knowledge sources.

In view of the availability of two New Zealand self-help manuals,[58] in addition to a raft of medically orientated literature – including educational audio and video programmes and booklets produced by the pharmaceutical industry – the women's dissatisfaction was surprising. However, their assessment that available information was either too difficult to understand or did not address their questions provided some insight. It appeared most sought experiential knowledge compatible with their common sense, life stage view. From this perspective, the 'flimsy', 'sensationalist' accounts of popular magazines that endorsed negative stereotypes of mid-life women at the mercy of 'the change', could be dismissed as extreme. Similarly, many found medically-orientated information difficult to understand because the deficiency disease orientation fell outside their common sense views, and so was unfamiliar.

Conversely, the women adopted a 'pick and choose' attitude toward those aspects of the deficiency disease model that endorsed their common sense views. This was evident through their association of menopause with ageing, health risk and the end of fertility. Informing these associations were first, the myriad negative stereotypes which cast the menopausal woman as a sexless crone plagued by emotional

instability and physical decrepitude. And second, the impact of a youth orientated culture where the greying of hair, altered skin tone and body shape together with a loss of fertility is incompatible with the norms of female physical and sexual attractiveness.

Sanctioning the women's common sense link between menopause and ageing was the evolutionary view of menopause as unique among primates because, 'the human female … outlives her reproductive span'.[59] This explanation made good sense to some like Jackie, because it confirmed her common sense association between menopause with ageing, loss of fertility and diminished sexuality. Similarly, pharmaceutical company educational material which linked oestrogen decline with bodily changes such as 'thin and dry skin', 'poorer quality hair'[60] and 'less supple less firm' breasts[61] was compatible with stereotypical notions of the crone and the values of a culture that equates female attractiveness with youth and fertility.[62] What is more, the portrayal of menopause as a time of 'emotional turbulence and uncertainty'[63] verified whispered gossip, childhood memories and so on, in the same way that the promotion of longer term risks of oestrogen deficiency endorsed the association of menopause with health risk.

A more complex process occurred with the women's use of the term 'hormone'. On the surface their employment of the word appeared to exemplify a notable characteristic of the process of medicalisation. That is, the incorporation of a specialised term into the vernacular which, in turn, reconstructs popular perception of a bodily event. While it could be argued that their use of the word 'hormone' was influenced by medical promotion of the deficiency disease model, closer inquiry revealed more than a one-way hegemonic process at play. The absence of experience-generated common sense knowledge encouraged the women to adopt the term in order to communicate previously taboo occurrences that lacked an explicit vocabulary. Now embedded within common sense discourse, the term 'hormone' had taken on new meanings and become vulgarised.

The constraint on the sharing of experiential knowledge exercised through the tradition of taboo was evident through symptoms identified as menopause-related among the women aged over sixty years. In all, these women attributed 14 symptoms to menopause, in contrast with the 31 recognised by those aged in their fifties and forties. The growing list of menopause-related symptoms acknowledged by the

younger women reflected two key factors: a) the erosion of the climate of taboo and the changing forms of stoicism; and b) the marketing of synthetic hormones.

What needs to be appreciated is that the onset of menopause among the women in the study occurred over a 32-year period. That is, between the years 1963 and 1995. Consequently, a number of the older women experienced this event in a much more socially constrained climate, where the sharing of experience was discouraged, and failure to control symptoms was deemed socially deviant. Under such circumstances, the experience of symptoms remained private and it is likely that mild to moderate symptoms often went unrecognised or were attributed to other factors, and forgotten over time. In contrast, the two younger groups were less affected by the constraints of the taboo and traditional stoicism, but more exposed to the promotion of HRT.[64] For these women, the deficiency disease model legitimated the experience of symptoms through allowing them to attribute to menopause a range of corporeal experience previously dismissed as a product of the mind. Indeed, it could also be argued that the promotion of HRT via tactics such as self-monitored symptom diaries or checklists,[65] encouraged the women to recognise a wider range of emotional and physical disturbances as evidence of menopause.

Strategies of symptoms control

Although around two-thirds had at some stage taken HRT, it would be misleading to conclude that these women were 'passive consumers … duped by medical technology'. On the contrary, the influence of common sense models on the women's decision-making processes was demonstrated in three notable ways. First, with the exception of those on HRT following a total hysterectomy, the women took the treatment for the management of immediate symptoms rather than for the benefit of their long-term health. Motivated by the desire for an improvement in their quality of life, and anxious to avoid being perceived as deviant because of an inability to cope, these women recognised that social conformity could now be achieved through medical assistance. However, the price of this conformity was tension between the desire to control the menopausal body, and achievement of this goal with pharmaceutical drugs. Although these women admitted they 'could not cope' without HRT, their unease over possible side-effects of the treatment demonstrated their ability

to make choices about the most effective strategies of symptom management. Second, with one exception, nine of the 23 women who had tired HRT discontinued within eight months. Dominating the decision to withdraw from the treatment was concern over possible side-effects, coupled with a dislike of 'putting chemicals into the body'.[66] Once again, rather than allowing themselves to be transformed into passive consumers 'duped by medical technology', these women demonstrated they were 'critical, reflexive agents' able to make a difference to their lives in a socially meaningful manner.[67] Finally, the women's aversion to ingestion of 'chemicals' or 'unnatural substances' into the body, signified their rejection of the medical model of menopause in favour of their common sense 'natural' life stage view. Not only did they object to the medical control over a normal life stage, but their comments drew attention to their awareness of the link between the promotion of HRT and the medicalisation of other aspects of women's reproductive functioning, particularly childbirth. Concerned that once on HRT they would no longer remain in control of the transition through menopause, they rejected the medication as 'unnatural'.

Conclusion

In response to concerns raised over the medicalisation of daily life associated with the marketing of wonder drugs, this paper has argued that lay resistance is an integral aspect of the process of medicalisation. Drawing on the response of a group of New Zealand women to the promotion and management of menopause as a disease of oestrogen deficiency, the discussion sought to establish that: a) far from being passive consumers manipulated by health professionals and the pharmaceutical industry alike, these women were active agents in the process of decision-making on the management of menopause; and b) the women's decision-making processes were most influenced by their common sense views.

For this group of women, the experience of menopause occurred against a backdrop taboo and stoicism that inhibited their sharing of common sense, experiential knowledge, and fostered the expectation that they would 'just get on with it'. Although the impact of the taboo was declining, both traditions continued to inform the women's expectations and experience of menopause as a 'normal', 'natural' stage in their reproductive lives.

Although the women were disinclined to accept the deficiency disease model of menopause, they did embrace those aspects of the medical model that were consistent with and/or reinforced their common sense views. Their association of menopause with ageing and ill health, the range of symptoms attributed to menopause, and use of the term 'hormone' all drew on aspects of the medical model and conferred legitimacy to their common sense views. Similarly, the use of HRT as a strategy of short-term symptom control, but rejection of aspects of the medical model not easily accommodated within their common sense views, identified their 'pick and choose' stance towards the marketing of this 'wonder drug'. In other words, as lay consumers, these women demonstrated they were active agents who possessed the ability to reconstruct, juxtapose or/and accept only those features of the medical model that were meaningful because they appeared compatible with their social obligations, individual aspirations and life circumstances.

The 'pick and choose' tactics, and resistance to the medicalisation of menopause identified among the women in this paper is consistent with the findings of several other studies.[68] Stephens, Budge and Carryer, for example, identified discourses of resistance among a group of New Zealand women, who described HRT as 'unnatural'. 'artificial' and an 'alien substance'.[69] Several British studies also uncovered resistance to medicalisation through strategies of active engagement in decisions on the management of symptoms, and a reluctant use of HRT. Additionally, Morris and Symonds noted how shifting social and cultural attitudes associated with the economic upheavals of the 1980s, influenced the views of a group of Welsh women towards the medical model of menopause. Reflecting aspects of the experience of their New Zealand counterparts, these women struggled to retain control of their bodies in the face of mixed messages from their cultural background, the promotion of HRT and workplace pressures. When seeking medical help for the management of menopause, they too adopted a 'pick and choose' stance to 'medically biased explanations and prescriptions'[70] and implemented solutions that were compatible with their common sense beliefs and interpretation of the meaning of menopause.

In view of the response to the promotion of menopause as a disease of oestrogen deficiency identified by women in this and other studies, it would appear that current concerns over the impact of the marketing

of wonder drugs may be unduly pessimistic. The difficulty with the disease mongering hypothesis is that it overlooks what the women in this study demonstrated and Lupton identifies as, 'the ways in which medical discourses are taken up, negotiated, or transformed by the lay population'.[71]

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Notes

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6 Stuart Hall, Bob Lumley and Gregor McLennan, 'Politics and Ideology. Gramsci' in Centre for Contemporary Cultural Studies (ed.), *On Ideology* (Hutcheson, London, 1978), pp. 77–105.

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13 See Justine Coupland and Angie Williams, 'Conflicting Discourses, Shifting Ideologies: Pharmaceutical, "Alternative" and Feminist Emancipatory Texts on Menopause', *Discourse & Society*, 13:4 (2002), 419–445.
14 Novo Nordisk Pharmaceuticals Ltd, *Voices of the Menopause* (Novo Nordisk Pharmaceuticals Ltd, Auckland, n.d.).
15 See, Wulf Utian, *Menopause in Modern Perspective: A Guide to Clinical Practice* (Appleton-Century-Crofts, New York, 1980).
16 Coney, *A Critical Look at Hormone Replacement Therapy*, p. 4.
17 Klein, *A Critical Look at Hormone Replacement Therapy*, p. 21
18 My emphasis.
19 Ayerst Laboratories Pty. Ltd., *Your Guide to Understanding Menopause* (Ayerst Laboratories New Zealand, Auckland, n.d.) p. 6.
20 Novo Nordisk Pharmaceuticals Ltd., p. 3.

21 See Bell; Coney, *The Menopause Industry; A Critical Look at Hormone Replacement Therapy*; Dumble; Kaufert and Gilbert; Klein.
22 Claire Budge, Christine Stephens and Jenny Carryer, 'Decision Making: New Zealand Women Speak About Doctors and HRT', *New Zealand Family Physician* 27:6 (2000), 41–47.
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24 Frances Griffiths, 'Women's Control and Choice Regarding HRT', *Social Science and Medicine*, 49:4 (1999), 469–481.
25 Margaret Morris and Angela Symonds, "'We've Been Trained to Put up With it": Real Women and the Menopause', *Critical Public Health*, 14:3 (2004), 311–323.
26 A. N. Beasley, 'Menopause in Context: A Constructivist/interpretative Perspective on the Attitudes, Perceptions, Expectations and Experiences Among Women in New Zealand', PhD thesis, Massey University, 1999.
27 The other aims were to: a) identify and examine the significance of wider social forces on women's perceptions and experience of menopause; b) identify past and current attitudes, common sense knowledge, myths and expectations towards menopause; and c) establish whether or not there were age group differences in women's experiences of menopause.
28 Writing Group for the Women's Health Initiative Investigators, 'Risks and Benefits of Estrogen Plus Progestin in Healthy Postmenopausal Women: Principle Results from the Women's Health Initiative Randomized Controlled Trial', *Journal of American Medical Association*, 288, (2002), 321–322.
29 In 1996 New Zealand became only one of two industrialised countries (the other is the USA) to allow direct to consumer advertising of prescription medicines. The ten drugs (which did not include HRT) originally promoted ranged from those for 'psychologically damaging life style ailments such as hair loss and sexual dysfunction to drugs for the treatment of asthma, high blood pressure, prostate cancer and obesity'. Ministry of Health, *Direct-to-Consumer Advertising of Prescription Medicines in New Zealand. A Discussion Paper* (Ministry of Health, Wellington, 2000), p. 31.
30 For example, a search of the magazine, *New Zealand Woman's Weekly* over the period 1942 to 1962, yielded only two direct references to 'the menopause' both of which were little more than asides in a series of articles titled 'The Secrets of Staying Young'. S. L. Solon, *New Zealand Woman's Weekly*, November (1957).
31 Replay Radio, *Menopause: A Period of Change for Women* (Radio New Zealand, Wellington, 1988).
32 Department of Health, Te Tari Ora, *Osteoporosis* (Department of Health, Te Tari Ora, Wellington, 1992); Department of Health, Te Tari Ora, *Menopause* (Department of Health, Te Tari Ora, Wellington, 1992).
33 For example, Ciba-Giegy Ltd., *Change of Life*, (Ciba-Giegy Ltd., Sydney,

n.d.); Novo Nordisk Parmeceuticals Ltd., *A Change for the Better: Menopause and HRT Explained* (Novo Nordisk Parmeceuticals Ltd., Auckland, 1994).

34 Coney, *The Menopause Industry.*

35 Margaret Durdin, North Island Education Co-ordinator, The New Zealand Family Planning Association (Wellington, 1996) personal communication.

36 W. Roger, 'The Baby Boomers Face 50, Talking 'bout my Generation', *North and South*, (1996), 57.

37 The panel members were: Professor John Hutton, gynaecologist, Wellington Menopause Clinic; Dr. Robyn Craven, medical practitioner, Jean Hailes Foundation, University of Melbourne; Dr. Anna Fenton, endocrinologist, Auckland Hospital; and Dr. Ruth Highet, sports physician, Wellington Sports Clinic.

38 IMS Health NZ Ltd., cited in Fiona North and Katrine Sharples, 'Changes in the use of Hormone Replacement Therapy in New Zealand from 1991–1997', *New Zealand Medical Journal*, 114:1133 (2001), 250–253.

39 North and Sharples.

40 Roberta Hill and Phillip Capper, 'Action Research', in Carl Davidson and Martin Tolich (eds.), *Social Science Research in New Zealand. Many Paths to Understanding* (Longman, Auckland, 1999), pp. 243–254.

41 The advertisement was published in the 8th January 1996 issue of the magazine's regular feature 'Your Helpline'.

42 'Provincial/rural' refers to geographical location; that is, those who lived outside the greater metropolitan areas of the five major cities of New Zealand (Auckland, Hamilton, Wellington, Christchurch and Dunedin).

43 Earl Babbie, *The Practice of Social Research, Eight Edition* (Wadsworth, Belmont, Ca., 1998) p. G65.

44 Robert Burgess, *In the Field: An Introduction to Field Research* (Routledge, London, 1993) p. 55.

45 Michael Quin Patton, *Qualitative Research & Evaluation Methods, Edition 3* (Sage, Thousand Oaks, 2002) p. 248.

46 Statistics New Zealand, *New Zealand Census of Population and Dwellings 1996* (Statistics New Zealand, Wellington, 1997).

47 Target Marketing Ltd., *Manawatu A–Z. Who's Who in: Feilding & District* (Target Marketing Ltd., Taupo, 1995).

48 A search of the social literature in 1996 identified only two Masters theses on menopause. See M. Hamilton, 'An Exploratory Study of Women's Experiences and Perceptions of Menopause Within the Context of Middle Age', MA thesis, University of Canterbury, 1990; P. Duncan, 'Experience and Attitudes of New Zealand Women to Menopause' MA thesis, Victoria University of Wellington, 1995. An earlier study had also been undertaken by the Society for Research on Women. This study surveyed 445 Christchurch women about mid-life health and experiences although not specifically on menopause this study did address a number of related issues such as possible links between mid-life stress and the incidence of menopause-related

symptoms. SROW (Society for Research on Women) *The Time of Our Lives: A Study of Mid-Life Women* (SROW, Christchurch, 1988).

49 Two of these women had yet to reach menopause, while the third response was indecipherable.

50 Mary Jacobus, Evelyn Fox Keller and Sally Shuttleworth, 'Introduction', in Mary Jacobus, Evelyn Fox Keller and Sally Shuttleworth (eds.), *Body/ Politics: Women and the Discourses of Science* (Routledge, London 1990) p. 2.

51 Claire Budge, Christine Stephens and Jenny Carryer, 'Decision Making: New Zealand Women Speak about Doctors and HRT', *New Zealand Family Physician*, 27:6 (2000), 41–47, identified similar concerns.

52 Librium and Valium are muscle relaxants that were commonly prescribed to mid-life women perceived as anxious or depressed, before HRT became more common place, see Coney, 1991.

53 Mary Breheney and Christine Stephens, 'Healthy Living and Keeping Busy. A Discourse Analysis of Mid-Aged Women's Attributions for Menopausal Experience', *Journal of Language and Social Psychology*, 22:2 (2003), 169–189, identified discourses around menopause which 'cast women as social actors within a moral order in which the absence of menopausal symptoms is an indicator of virtuous behaviour, and a moral imperative' (p. 169).

54 See, for example, Coney 1991.

55 Christine Stephens, Jenny Carryer and Claire Budge, 'To Have or to Take: Discourse, Positioning, and Narative Identity in Women's Accounts of HRT', *Health: An Interdisciplinary Journal for the Social Study of Health, Illness and Medicine*, 8 (2004), 329–350 found the biomedical repertoire allowed a group of New Zealand women 'to draw on medical terms to describe their experiences [of menopause which] were described in terms such as *symptoms*, *disease*, *hormones*, *side-effects*, *risks*, *genes*, *osteoporosis*, and *cancer*' (p. 351).

56 3M Pharmaceuticals, *Understanding Menopause* (3M Pharmaceuticals, Auckland, n.d.).

57 At the time of the study, the debate of possible side-effects was anything but clear cut. Groups such as the Australian Menopause Society, *A Statement by the Australian Menopause Society on Hormone Replacement and Breast Cancer* (Australian Menopause Society, Glenside, SA, 1995) were claiming that HRT was safe if 'given short-term (for up to five years) for the treatment of menopause-related symptoms and long-term, where indicated to reduce the risks of heart disease and osteoporotic fractures'. In contrast, interim results from the Nurses' Study identified a modest increase in breast cancer among post-menopausal nurses after five years of oestrogen treatment. G. A. Colditz, S. E. Hankison, D. J. Hunter, W. C. Willet, J. E. Manson, M. J. Stampfer, C. Hennekens, B. Rosner and F. E. Speizer, 'The Use of Estrogens and Progestins and the Risk of Breast Cancer in Postmenopausal Women' *New England Journal of Medicine*, 332 (1995), 1589–1593.

58 None of the women indicated their awareness of the two New Zealand manuals: Raewyn MacKenzie, *Menopause* (Reed Methuen, Auckland, 1984); Leticia Potter, *Women in Mid Life* (New Women's Press, Auckland, 1991).
59 3M Pharmaceuticals.
60 Schering (NZ) Ltd., *The Menopause* (Schering [NZ] Ltd., n.d.).
61 CIBA-Geigy NZ Ltd., *Living Through Change* (CIBA-Geigy NZ Ltd., n.d.) p. 7.
62 See, Nancy Avis and Sonja McKinlay, 'A Longitudinal Analysis of Women's Attitudes Toward the Menopause: Results from the Massachusetts Women's Health Study', *Maturitas*, 12 (1991) pp. 65–79; Margaret Lock, *Encounters With Aging: Mythologies of Menopause in Japan and North America* (University of California Press, Berkeley, 1995); J. Marmorco, J. B. Brown, H. R. Batty, S. Cummings and M. Powell, M. 'Hormone Replacement Therapy: Determinants of Women's Decisions', *Patient Education and Counseling,* 33, (1998), 289–298; H.J. Wright, 'The Female Perspective: Women's Attitudes Towards Urogenital Aging', in Barry Wren (ed.), *Progress in the Management of the Menopause* (Parthenon, New York, 1997), pp. 476–480.
63 Novo Nordisk Pharmaceuticals Ltd., *Voices of the Menopause* (Novo Nordisk Pharmaceuticals Ltd., n.d.) p. 3.
64 See North and Sharples; Coney *The menopause Industry.*
65 See Ayerst Laboratories Pty. Ltd., 'Premarin/Prempak-C Screening Questionnaire', *The Promise of the Mature Years* (Ayerst Laboratories Pty. Ltd., Parramatta, n.d.); Ciba-Giegy (NZ) Ltd., *Menopause Symptom Diary.*
66 O'Leary Cobb refers to a similar rationale among some Canadian women who were reluctant to go on HRT. J. O'Leary Cobb, 'Why women Choose not to Take Hormone Therapy' in G. Berg and M. Hammer (eds.), *The Modern Management of Menopause: A Perspective for the 21st Century* (Parthenon, New York, 1994), pp. 525–532.
67 Williams and Calnan, p. 1613.
68 See Christine Stephens, Claire Budge and Jenny Carryer, 'What is This Thing Called Hormone Replacement Therapy? Discursive Construction of Medication in Situated Practice' *Qualitative Health Research*, 12:3 (2002); Hunter, O'Dea and Britten, 1997; Griffith 1999; Morris and Symonds, 2004.
69 Stephens, Carryer and Budge, pp. 33–43.
70 Morris and Symonds p. 316.
71 Lupton, p. 96.