UNIT 5 – Cycles of Change: Menstruation and Menopause

OVERVIEW

In this unit, two of the most important health events that women experience are considered: menstruation and menopause. Menstruation is the beginning of women's reproductive years; menopause ends the cycle. They are health events that all women experience differently and yet they are similar in many ways. Part I of the unit looks at menstruation Part II looks at what is commonly referred to as premenstrual syndrome (PMS) and also looks at menstrual suppression and a feminist view of PMS. Part III considers menopause and the final section, Part IV, looks at the debate and discussion that have swirled around prescribing hormone therapy (HT) as a way of dealing with the short term and long term health issues usually associated with menopause.

The four parts of this unit are:

PART I	Menstruation
PART II	What We Call Premenstrual Syndrome (PMS)
PART III	Menopause
PART IV	Hormone Replacement Therapy: Debates and Discussion

LEARNING OUTCOMES

In Unit 5 you will:

1. learn about menstruation;
2. evaluate some of the ideas about premenstrual syndrome;
3. briefly examine the process of menopause;
4. consider the debate and discussion that have surrounded hormone therapy.

UNIT FIVE

All readings are available online from the J.N. Desmarais Library or the internet and are linked from the course website (see the Study Guide for details).

ASSIGNED READING

Loshny, "From Birth Control to Menstrual Control: The Launch of the Extended Oral Contraceptive, Seasonale", pages 63-67.

Lee, "Health and Sickness: The Meaning of Menstruation and Premenstrual Syndrome in Women's Lives."

Santoro, DeSoto and Lee, "Hormone Therapy and Menopause"

Allina and Fugh-Berman, "Natural Hormones: Are They a Safe Alternative?"

INTRODUCTION

Menstruation is not an unusual event in women's lives. Most women menstruate fairly regularly between the ages of 13 and 50. Allowing for two pregnancies, these women will menstruate four hundred times before menopause, or the cessation of their menstrual cycle. Even though this monthly event is experienced by almost half of the human population it is usually done in an atmosphere shrouded in secrecy. For most women it is a private, hidden event; for others it is something shameful. Because of the mystique that surrounds menstruation, we actually know little about what women think about it, or how they cope with it. In Sophie Law's research she identifies what she terms "menstrual etiquette." It involves never talking about menstruation in front of men and even when talking to women the monthly cycle is referred to euphemistically. Part I of the unit is largely descriptive, and looks at menstruation as a physiological event and considers what most women can expect when they menstruate. Part II looks at what has come to be referred to in western society as premenstrual syndrome (PMS) and considers some of the arguments used to challenge the popular western construction of PMS.

Like menstruation, menopause is something that all women who menstruate will experience. If menstruation is the beginning of women's reproductive years, menopause is the end of that cycle. Today interest in menopause is at an all time high. The aging of the Canadian population means that never before have so many women faced their menopausal years. Fifty-year old women who have no intention of saying that their reproductive life is over or that they are no longer sexual beings are challenging negative attitudes towards menopause as the "beginning of the end". In fact, many women see midlife as the beginning of a new era for them. The health challenges that it may pose are increasingly viewed as normal and similar to other health challenges that women face throughout the first part of their lives. Part III of this unit deals with an overview of menopause and the health issues that women go through menopause will face. In the final section of the unit, Part IV challenges the notion that menopause is a deficiency disease in need of hormone therapy. The section ends with ways that midlife women can be empowered by demedicalize menopause.

KEY CONCEPTS

- feminist view of PMS
- what we call PMS
- "code" name for the menstrual cycle
- dysmenorrheal
- menstrual suppression
- feminist view of PMS
- getting relief from the signs of PMS
- fear of aging
- factors contributing to women's physical and mental well being as they age
- findings of the Women's Health Initiative regarding hormone therapy

PART I – Menstruation

Please read, Lee, "Health and Sickness: The Meaning of Menstruation and Premenstrual Syndrome in Women's Lives."

While it may seem simplistic menstruation is the beginning of women's reproductive years. In western culture it is largely a "secret" event. In fact, so secret that many women report not even knowing what was happening to them. Certainly books like Judy Bloom's *Art You There God, It's Me Margaret* has helped to introduce many girls to the wonders of menstruation. The fact that Bloom's book has been banned from many libraries and schools attests to the fact that many people still think that open talk about menstruation is inappropriate. The fact that women use code names when referring menstruating is also suggestive of the way that this commonplace event is hidden from view.

STOP AND THINK

List as many "code" names as you can that are used to signal to other people that a woman is having her menstrual cycle:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Some common euphemisms are: "I have a visitor," "I have my period," and, of course, "the curse" have always been popular. Some of the terms listed in Karen Houppert's book *The Curse: Confronting the Last Unmentionable Taboo: Menstruation* (1999) are "the plague," "the visitations," "monthly troubles," "that time of the month," "monthlies," "old faithful," "indisposed," "sick time," "under the weather," "on the rag," "the red flag is up," "red letter day," "my redheaded friend," "traveling the red road," "are you feeling red?" and so on.

When we think of the way that menstruation has been defined over time, it is not surprising that women should try to avoid letting anyone know that they are menstruating. Biblical images of the menstruating women are less than flattering. In the Bible a summary of chapter 15 of the book of Leviticus states that whenever a woman is menstruating, she should leave the village (or tribe) for the duration of her cycle. Any rock she sits on, any person she talks to or anything she touches is cursed and unclean. She can only redeem herself at the end of her cycle by having the priest make "atonement for her before the Lord for her unclean

discharge" (v. 30). The Christian religion is not alone in its views of the menstruating woman. Islam's holy book, the Quran, ii: 222 admonishes men to "keep away from women in their courses [menstruation], and do not approach them until they are clean…God loves those who keep themselves pure and clean."

Certainly religious injunction against what one should or should not do during menstruation does not have the hold that it once did. However, there is evidence that suggests that menstruation is still not the topic of polite conversation. When we see menstrual products advertised on television and in magazines they actually reinforce the secrecy of menstruation by assuming an understanding about the product without actually using the word "menstruation" or "menstrual blood" (Walker 20). Walker also argues that the advertisements create fears and concern in women as they suggest that women must always be on guard against leakage and, even worse, odours (20). What emerges again is the female body as a source of pollution.

With all the mystery and ambiguity about this monthly event, it is not surprising that negative images of the menstruating women have come down through the ages. Nor is it surprising that women would want to hide the fact that they are menstruating. The menstruating woman has been the butt of jokes, the subject of irrational fears and the stuff of mystery and ritual. Women as well as men held these notions. For example, there are women who believed that if they tended their plants during the time they were menstruating the plants would die. Men have been warned that menstrual blood is a threat to their sex organs.

In some ancient cultures, particularly those that were matriarchal or those practicing goddess worship, menstruation was seen in a more positive light. Walker refers to several authors who have studied cultures where there is some evidence to suggest that the menstruating woman was seen as powerful and a symbol of life and fertility (21). Menstrual blood has been used in these cultures in fertility rites, as a fertilizer, a love potion or a healing agent (21). In fact, it appears that the use of menstrual blood as a healing agent was common in some places well into the Middle Ages (21).

Modern versions of the menstruating women can be found in accounts of the cultures of First Nations peoples. Their women were often thought to be more spiritual and physically more powerful during the time that they were menstruating (22). Walker argues that while Nootka women from the Pacific Northwest retreated to a "moon lodge" during menstruation, the event was intended as a time of relaxation and enjoyment (22). While many myths have informed contemporary woman's perception of menstruation, not all women accept the negative imagery. There is evidence that many young women today look forward to the start of their menstrual cycle. Women who menstruate regularly, and complain half heartedly about it, need to be reminded of the dramatic act that plays out in their bodies each month when menstruation begins.

MYTHS ABOUT MENSTRUATION

Misconceptions and myths about menopause have always existed and no doubt they grow out of the secrecy that has surrounded women's monthly cycle. Here are some contemporary menstrual myths:

Myth 1: You should avoid exercising during menstruation.

There is no reason to avoid exercise when you are menstruating. Women who remain active during the time they are menstruating report less menstrual discomfort than inactive women and many women find exercise helps relieve menstrual cramps.

Myth 2: You will lose your virginity if you use tampons.

The only way you can "lose your virginity" is to have sexual intercourse. Using a tampon does not damage the hymen (the think membrane inside the vagina that has traditionally been associated with virginity).

Myth 3: It is impossible to get pregnant during your period.

It is less likely that you will get pregnant during your period, but it is not impossible. Always use a reliable method of birth control whenever you have intercourse.

Myth 4: It is unhealthy to have sex when you are menstruating.

This is without doubt one of the oldest taboos. There is no medical reason for avoiding sexual intercourse when you are menstruating.

Myth 5: Menstrual discomforts are all in your head.

Many women experience some level of discomfort, usually prior to the start of menstruation. Some women experience more discomfort than others (American Medical Association 208).

IDEAS TO REFLECT ON

As you read the article by Lee, answer the following questions:

1. What is the purpose of the author's research?
2. "Attitudes [towards menstruation] ranged across a broad spectrum from extremely negative to extremely positive" (176). Provide an example (one positive and one negative) from the narratives of women interviewed for this research.
3. According to the author most of the women interviewed were well educated and most likely represented middle-class women (177). Do you think this had any bearing on the fact that many had positive attitudes towards menstruation and PMS? Explain your answer?
4. What are some of the aspects of menstruation that led women to see it as a negative experience?
5. For those women who see menstruation positively, on what do they base this view?
6. To what extent did the women who were a part of this study think of the PMS label was appropriate?
7. What connection can you make between the author's conclusion that "one of the most important results of the study was the identification of a group of women who were extremely positive" about menstruation and the menstrual joy questionnaire discussed in the unit?

PART II – What We Call Premenstrual Syndrome (PMS)

Please read, Loshny, "From Birth Control to Menstrual Control: The Launch of the Extended Oral Contraceptive, *Seasonale."*

Whether it is Dolly Parton belting out "I've Got the PMS Blues," a television talk show or an article in a popular woman's magazine PMS has entered the cultural landscape, at least in western countries. An informal definition of PMS refers to the cluster of changes, feelings and sensations that some woman experience in the days before the onset of menstruation and that usually disappear when menstruation begins.

When discussing any of the discomforts that for many women are a part of their monthly cycle, women usually refer to all of the various signs (cramps, bloating, irritability, weepiness, and so on) as PMS. While we do not have an agreed upon definition of premenstrual syndrome Davis separates dysmenorrhea, the abdominal cramping, backache and bloating, associated with elevated levels of prostaglandins, from premenstrual syndrome which she argues is primarily the mood swings and alterations in behaviour such as irritability, weepiness and so on that often accompany menstruation. These mood swings and so on are usually associated with fluctuations in hormone levels (Davis 59). Davis argues that unlike dysmenorrhea, which is clearly tied to the start of menstruation, "there has been a failure to actually document the mood fluctuations attributed to PMS over the menstrual cycle." However, when used in this section of the unit the term PMS will refer to the physical and emotional changes that are associated with the onset of menstruation.

Feminist health activists and many others working in the field of women's health, challenge many of the assumptions that shape society's beliefs about what signs, feelings, and sensations make up what is commonly referred to as PMS. They contend that our understanding of PMS is based on unproven assumptions. There is confusion about how many women are affected by PMS, exactly what sensations are experienced, how severe they are and what causes them. Davis cites Fausto-Sterling who claims, "never have so many for so long, done such poor research" (58). As noted already, researchers do not even agree upon a definition of PMS (Lee 20). Some of the issues that will be pursued below are the lack of a standard definition for PMS, how incapacitating the signs are, whether the changes that occur are the result of fluctuating hormones. Finally, an attempt to formulate a feminist view of what we call PMS will conclude the section.

Problems with the definition: Lee (20) argues that a review of the research on PMS shows that there are fundamental problems on the impact of menstruation on women. Researchers have found that as few as 5% and as many as 95% of women claim to experience PMS suggesting that the definitions they are using vary widely. She goes as far as to say that the lack of a definition means that we know little about what the actual signs are that make up the so-called syndrome, how many women are afflicted with it, how it impacts women's lives, how long it lasts, or what part of the menstrual cycle is associated with it. If researchers are unable to define PMS it raises questions about whether it really exists. There is no doubt that women experience discomfort, usually prior to menstruation, but does this indicate a syndrome, a disorder or an illness that needs medical treatment? It may be that only a very few women have signs so severe that treatment is necessary. But a definition of what is occurring is necessary before the labelling process should begin.

Women's reduced ability to perform tasks: Since its publication in 1969 Katharina Dalton's book *The Menstrual Cycle* has been used to support the negative impact of menstruation on women's daily lives. She argued that women's efficiency at work is reduced during menstruation and that women have higher rates of absenteeism from employment during this time of the month. She also claimed that the signs associated with the onset of menstruation strain marriages because of women's bad housekeeping during this time and their irritability and ill temper (Walker 75). In fact there is no evidence to support the claim that women perform below what is normal in either their domestic or employment duties. American statistics show that women are absent no more often from their work than are men, which would refute the claim of high absenteeism among menstruating women. Lee reports on a literature review which revealed that there are no changes in examination performance or in a comprehensive range of experimental tasks that tested cognitive abilities during menstruation (Lee 19; Walker 90). The notion, as proposed by Dalton, that during menstruation women should be barred from doing complex tasks and given only light duties is unsupportable and "may be better understood as arising from negative social myths about women and about menstruation than as having any basis in fact" (Lee 23).

What we call PMS is based on hormonal changes: One of the questions that still requires an answer, despite decades of research, is whether or not what we call PMS occurs because of hormonal changes in a woman's body prior to menstruation. Some writers, such as Dalton, who follow the "biology is destiny" line of thinking, argue that insufficient levels of the hormone progesterone cause premenstrual problems. She suggests that women take progesterone to ward off the sensations associated with PMS. However, Lee cites research that shows that in randomized controlled studies no difference in levels of PMS was found between women given hormone treatments and those given a placebo, that is, fake treatments. In fact there appears to be a large placebo effect, that is, even women on the placebo think they feel better which may suggest that there are psychological and social factors at play (Lee 23).

One of the answers to dealing with the discomforts of PMS is to simply do away with periods altogether or significantly reduce them. Having a monthly period is increasingly becoming a lifestyle choice. Some women choose to use menstrual suppression to deal with a holiday, a honeymoon, the examination period, a job interview or a high pressure period at work. Menstrual suppression is also used to deal with medical problems such as endometriosis or menstrual migraines. Others see it as a way of ending what is for some women is a debilitating time of the month, a time when they have to miss work or school because of the pain they experience. Menstrual suppression drugs such as *Depo-Provera* and *Seasonale* receive high praise from some medical practitioners who use the drug themselves. Using menstrual suppression for its convenience factor is a newer concept and one that is catching on among women.

The question is – is menstrual suppression good for women's health? One argument put forward is that any woman on oral contraceptives is already having their period manipulated. Birth control pills block ovulation; women then begin to bleed when hormone levels drop during the week they take the placebo pills. It is then that the lining of the uterus breaks down and bleeding begins.

Those in favour of menstrual suppression point to a generally good safety profile for oral contraceptives which, they argue, have been studies since the 1960s. They also argue that these drugs have been shown to cut the risk of endometrial and ovarian cancers and anemia. However, the long term effects of the drugs are not fully known and many of those who support menstrual

suppression have to admit that women who use menstrual suppression are a part of an experiment and no one knows how it will end (webmd.com).

One person who is against the experiment is Dr. Jerilynn Prior a professor of endocrinology at the University of British Columbia. Prior believes that a normal menstrual cycle is crucial to women's health, and that women experience a menstrual cycle for reasons other than its reproductive purpose. She argues that "normal menstruation has beneficial effects on women's bone and cardiovascular health" (webmd.com). To suggest, Prior argues, that "periods don't matter" is simply unscientific. Prior gets some support for her ideas from the Society for Menstrual Cycle Research which acknowledges that menstrual suppression may help some women with severe menstrual problems but the association says "We do not believe that continuous oral contraception should be prescribed to all menstruating women out of a rejection of normal, healthy menstrual cycle" (menstruationresearch.org).

The Society points out that there is not enough data to suggest that menstrual suppression is safe and argues for more research into the health effects of menstrual suppression particularly its effects on bone health, particularly for adolescent girls whose bones are still growing, risks for blood clots and strokes, and effects on fertility as well as on other aspects of women's health.

✍ IDEAS TO REFLECT ON

As you read the article by Loshny on *Seasonal* consider the following points:

1.On what basis do researchers cited in this article support the idea of menstrual suppression?
2.Why is it that menstruation and menopause are being viewed as problems that need to be fixed?
3. What role does the pharmaceutical industry play in the medicalization of both menstruation and menopause?

Feminist view of what we call PMS

The feminist view of PMS challenges the notion that PMS is either a disease or a psychiatric illness or anything other than a natural monthly occurrence for women, albeit one that causes some women various levels of discomfort. Feminists ask women to think about the positive aspects of menstruation (Davis 61). Both the popular media and the medical community persist in infusing menstruation with myth and mystery and pay little attention to women's experience of menstruation. A number of research studies have documented that in the time before the onset of menstruation many women experience a heightened sensitivity and creativity. For others it is a time for self-reflection and insight (Davis 61). Lee reports that in one study two-thirds of the women reported at least one positive change during the week before menstruation (Lee 19). These included increased sexual interest and enjoyment, renewed energy, a tendency to get things done, and a perception of increased attractiveness, and yet this is a point that researchers have largely ignored (Lee 20).

In attempting to explore the extent to which women experience positive physical changes prior to and during menstruation, Chrisler, Johnston, Champagn, and Preston (1994) devised the Menstrual Joy Questionnaire and reported their findings in "Menstrual Joy: The Construct and Its Consequences." These researchers were curious about women's experience of menstruation. They were familiar with literature from many sources reporting women's positive and negative feelings but were aware that negative imagery far outweighed the positive images. They found in

their literature review that boys and premenstrual girls held more negative ideas about menstruation that did girls who were actually menstruating (375). They argue that negative attitudes about menstruation have permeated our society and are reinforced by popular culture. For example, articles in American magazines during the 1980s revealed a strong bias in reporting on negative and even exaggerated physiological changes that women were supposed to experience during menstruation (376). Not only were the articles negative in tone, but also they presented a confusing array of symptoms and the treatments suggested were often contradictory. More often that not these accounts supported stereotypes of women's erratic behaviour and even suggested that premenstrual women needed psychiatric care. Some of the titles of magazine articles, as cited by Chrisler et al., were "Dr. Jekyll and Ms. Hyde," "Coping with Eve's Curse," and "The Taming of the Shrew Inside of You" (377).

Chrisler et al. were also aware that there was a body of research that showed that women also had positive experiences during menstruation particularly increased productivity and creativity as mentioned above. It was from this notion that one researcher devised the Menstrual Joy Questionnaire. Those who have used this research tool realize that its very name could bias responses. In fact, many researchers who have used the questionnaire have avoided using its title. The results of the study done by Chrisler et al. and others that have used the Menstrual Joy Questionnaire are inconclusive but do suggest that many women have negative attitudes about menstruation. However, Chrisler et al. argue that menstruation could be a joyful experience [and the questionnaire] "stimulated the participants to think about positive menstrual cycle-related events as well as the affirming aspects of menstruation on their personal lives (Chrisler, et al. 382).

While some women who participated in the various studies thought that the idea of a Menstrual Joy Questionnaire must be a joke, other "seemed delighted by the idea that menstruation could be joyful and that researchers would take an interest in its positive aspects" (382). Chrisler, et al., feel that their research contributes to a growing interest in finding out more about women's experience of menstruation, particularly its positive side. They insist, however, that their work provides evidence for what many researchers have noted for some time: the portrayal of the menstrual cycle in popular culture affects the way women think about this event (386). The problem with any research on menstruation and PMS specifically is that the negative images of menstruation are so pervasive in our society it is difficult to get anyone, men or women, to think about this event in a new and positive way. Chrisler et al. are convinced that simply suggesting to women that there are positive aspects to menstruation had an impact on the women who participated in their study. "This underscores the need for better menstrual education and more openness, in general, about the diversity of menstrual experience" (386).

The research of Chrisler et al. supports the idea that what we call PMS is a culturally defined and largely invented concept. Lee cites Ussher who goes as far to say that PMS as a concept is not valid. PMS, Ussher claims, is a political, not a medical category. It controls women. It ties women to their biology. It dismisses women's anger (Lee 27). One researcher has traced the emergence of PMS to women's entry into the labour force (Lee 22). The way that authors such as Katherina Dalton have constructed menstruation, that is, as an illness that will hinder women from being effective employees, justifies relegating them to low paid, part-time employment, which is, in fact, exactly where most women are in the labour force. Much of the discussion around PMS concerns reports that women experience considerable irritability around this time of the month which one medical doctor said caused the "husbands and families of these women to be pitied" (Davis 76 note 3). This would suggest that the doctor's treatment of women,

which could include drugs and surgery, i.e., the removal of the uterus, would be done for the comfort of men and not for the benefit of women. In fact, the image of the angry, irritable woman is one that we reject in our culture. Women are supposed to be long suffering, placid, and kind not subject to mood swings or bad temper. Women who become irritated and angry are viewed as being out of control. Therefore the search for a medication to "cure" the feelings that women experience at menstruation becomes an ongoing process.

The problem with the feminist position is that it can lead some to think that feminists are saying that women's discomfort at menstruation is not real. In fact, all of the feminist health activists cited here such as Lee, Davis and Walker acknowledge women's premenstrual health concerns but argue that they are not as widespread or as debilitating as some would suggest and should not be seen as a medical problem. Feminists do ask women to look at menstruation differently and to see if they can turn this time of the month to their advantage. The problem with accepting theories such as the one that says that the signs of menstruation are caused by an imbalance of hormones suggests that the addition of hormones would balance everything out.

Semler argues that even though we cannot explain what it is, we do know that many women experience some discomfort around the time of menstruation. We also know that the degree of discomfort ranges from mild to severe. However, only a very small minority of women, (about 5%), find the changes incapacitating (142). Semler claims that the only real definition is the one that an individual woman can formulate to reflect her own experience. In most instances what we call PMS is a group of signs, or changes that occur about a week before menstruation. When most people refer to PMS they are overlapping it with dysmenorrhea, the cramping, and bloating that occurs prior to menstruation, and include the emotional signs of weepiness and irritability (142).

It is thought that young women, those just beginning their menstrual experience, and those women who are heading into menopause, have more menstrual disruptions than do women generally. It appears that the largest group of women who attend PMS clinics are women in their 30s and 40s who have two or more children. Others have found that what we call PMS increases as women age. This could suggest that as the pressure of domestic work coupled with employment outside the home, relationship problems, the responsibilities of caring for aging parents can create stresses on women that exacerbate the signs that women experience at menstruation. Semler is quick to point out, however, that it has not been shown that stress causes PMS, but stress may accentuate the signs that are present and anything that can be done to reduce stress at this time of the month could help. There are a number of other things that women can do to get relief from the signs of PMS:

- Let those closest to you know that you are menstruating or that this is your time of the month. Let them know that you may be more energetic or in a more adventurous or creative mind set than usual; or that you may be more emotional or irritable than normal. Let them be aware that you may be more demanding, or that you may need more help than usual.
- Take time for yourself. Go for a long walk or do some other kind of exercise that you enjoy. This can help to release endorphins that can boost mood and reduce pain.
- Get extra sleep. This way your body will be able to handle some discomfort.
- Take a warm bath. If possible, have a massage.

- Pay attention to your diet. Eat lots of fruits and vegetables and consume less sugar, and foods high in caffeine.
- Limiting salt intake and drinking lots of water can reduce the discomfort that comes with bloating (American Medical Association 209).

What is telling about some of the general discussions on menstruation is that we actually know little about one of the most common health issues that face women today. PMS has not been clearly defined; we do not know which of the signs are most common to women nor do we know how many women are affected either mildly or severely. One area that needs more study is cross-culture comparisons of women's experience with menstruation. Such knowledge would provide valuable insights into this phenomenon (Davis 64). We do know that much more work needs to be done before we fully understand women's health concerns when they are menstruating.

PART III - Menopause

The term menopause refers to a woman's final menstrual period. Unlike menstruation the onset of which is sudden and visible by an obvious show of blood, menopause is a gradual process that begins in women who are between 40 and 55; the average woman in North American reaches menopause at age 51 but this can vary widely. Menopause, often referred to as the climacteric, is a result of the slowing down of the production of estrogen and other hormones. It is not, as many have claimed, a deficiency disease in search of a cure (Cobb 199219). Like puberty, which begins with the onset of menstruation, menopause is the end of that cycle, and as such it is a normal, healthy phase in a woman's life.

The term menopause is often used by women to include the entire menopausal process. In fact, menopause can be broken down into three distinct but overlapping phases. The "perimenopause" refers to a period, which varies in length depending on the woman, prior to menopause itself. During the perimenopause some women begin to experience changes in their menstrual cycle; many women have no signs that menopause is approaching. Irregular periods is the most common early indication of menopause. A woman's monthly period, heretofore fairly regular, can become either further apart or closer together; the blood flow may also change becoming either lighter or heavier. A woman only knows retrospectively that she has completed the menopausal cycle. The absence of menstruation for one year signals the end of menopause. This begins of the third phase, the "post menopausal" period (Davis 68). With the end of menopause and the beginning of "post-menopausal" most of the signs associated with menopause disappear (Canadian Women's Health Network/Menopause).

THE SIGNS AND SENSATIONS OF MENOPAUSE

The signs that signal the onset of menopause can be broken down into three categories:

vasomotor such as hot flushes and night sweats;

psychological signs such as tiredness, forgetfulness, irritability, nervousness, problems with concentration; and,

psychosomatic signs such as headaches, palpitations, dizziness (Lee 43).

Although much is made of the signs or sensations of menopause (the terms "signs" and "sensations" are used here rather than the notion of symptoms since the latter suggests disease is present) there is sufficient evidence that not all women experience any or all of these signs (Cobb 19). Hot flushes and night sweats are the most commonly experienced menopausal signs and the only ones which are reported across cultures (Lee 43). Vaginal dryness is also reported, however, Davis claims that only 5% of women experience this sign. While we know that these signs exist, we know much less about how or why they occur (Davis 69).

Hot flushes and vaginal dryness are some of the short-term signs of menopause. Other health problems have also been associated with menopause: osteoporosis (weakening of the bones) and heart disease. But do these occur because of menopause or are they, as Cobb suggests, or are they a normal part of the aging process (69)? For example, osteoporosis begins well before any signs of menopause are present and only 25% of women get the disease.

A number of researchers have challenged the assumption that women's health is jeopardized because of menopause. Research indicates that even the most common sign of menopause, the hot flush, is often experienced by women no more than once (Lee 44). While hot flushes are reported globally, the degree to which they are experienced by women in some cultures is considerably less than in western societies (deSousa 56). This is not to discount the fact that some women do suffer considerably from hot flushes and particularly from night sweats. The latter can interrupt sleep to the extent that there is a decrease in a woman's quality of life. Lee argues that although there is the widespread assumption that women going through menopause suffer from depression, she cites research which show that there is little evidence to suggest that peri- and post-menopausal women are particularly prone to depression or to other negative psychological states (44). The authors of *Out Bodies, Ourselves* argue that a recent study that investigated the connection between depression and menopause found that no such link exists (555).

Certainly, as women (and men) age, health problems become more acute. Lee points out that there are well-documented long-term physical effects associated with aging. Women are more prone to heart disease as they age and it is the leading killer of women. As well, osteoporosis is responsible for high rates of ill health and even early death among women (Lee 45), and breast cancer is more likely to appear in women in old age.

THE HEALTH OF MIDLIFE WOMEN

Cobb (1992) in her article entitled "Menopause or Aging? challenges the notion that menopause is a problem for women generally and it is certainly not a disease in need of treatment (19). Some women do experience more acute signs and sensations than others. While most women take the signs of menopause in stride and follow a self-help approach, those who do experience more bothersome signs may prefer to talk these over with their medical practitioner.

Feminists have long advocated that women's mid-life health issues, including the sign and sensations of menopause, must be placed within the context of their lives. In other words, it is important to ask what is going in their lives that may be contributing to what they feel are changes in their health status, changes that are often blamed on menopause and age. Feminist scholars have been pointing out the way in which the problems that women face at midlife are not legitimized as real. Rather, they are dismissed or identified as hormonal and will go away with treatment, usually with prescribing hormone therapy. In the same way as the premenstrual woman is often stigmatized as being incapable of acting rationally during menstruation, ageism, discrimination based on age, and sexism, discrimination based on sex, combine to create an even harsher stereotype of the midlife women who is going through menopause (Lee 48).

The midlife woman can be facing changes that impact on the way she sees herself and the way she feels about her life. It may be necessary for her to deal with stressful life situations that challenge her mental and physical health.

STOP AND THINK

List as many personal and domestic events that may take place in a woman's life and cause her considerable distress and health problems:

_____ _____

_____ _____

_____ _____

It is not unusual for mid-life women to experience changes to their lives that are substantial. Many of the changes will impact on women physically as well as psychologically. Women going through the menopause or the perimenopause years are more likely than other women to be going through a divorce, the illness or death of a spouse, or coping with the death or disability of aging parents and even be responsible for their care. Children leave home; children return home bringing with them financial worries especially if they have their own children in tow. As well, re-entry into the work force after a period of employment inactivity, or employment related problems such as loss of job or forced retirement can cause a great deal of stress. Health issues often must be confronted at this time of life when a diagnosis of heart disease, cancer, and osteoporosis or the fear of such a diagnosis can cloud rational thinking. In a culture that reveres youth and rewards beauty women will often do what is necessary to avoid the signs of aging. In fact Cobb claims that for the menopausal woman "the crucial issue to be confronted is aging" (20). Graying hair, wrinkles that defy the creams advertised in magazines, and the weight gain that is evident as a woman's metabolism slows can contribute to negative

self perceptions and self-worth. Cobb goes on to say that "if a woman can successfully deal with her fear of aging—the negative images we have of aging women, the lack of positive role models of women in their 50s and 60s—menopause becomes much easier to deal with" (20).

Mid-life women may see menopause as the onset of old age since menopause is often viewed generally as a biomedical event representing the end of youth and the deterioration and decline into old age (Lee 49). In fact, some of the statistics regarding older women in Canadian society suggest that there is much for mid-life women to be concerned about regarding their future. The Canadian Women's Health Network cites a number of factors that contribute to women's physical and mental well being as they age:

- In 1999, women aged 65-69 had an average yearly income (after tax) of $18,427; for men it was $22,577.
- 88% of women aged 65 and over have a health problem.
- Older women are more likely to live alone, with inadequate social and material support.
- When living with a male partner, an older woman is usually the one providing care if he becomes ill or disabled.
- Women are more prone to suffer from Alzheimer's disease, osteoporosis, a chronic disease, falls, vision problems, and they spend more days in hospital than men.
- 5.8% of all seniors in 1996 belong to a visible minority group.
- Senior women are prescribed mood-altering drugs (i.e., minor tranquilizers and sedatives) more often than any other population group in Canada.
- In studies of elder abuse, those most likely to be abused are older widows who live with a relative, are socially isolated and are in poor physical or mental health.
- Of older women who are assaulted, more than one-in-four are assaulted by a family member, compared to one-in-seven older males.

Lee argues that women who have embraced traditional gender roles and who value youth and physical attractiveness over maturity and wisdom are more likely to view menopause negatively and these women may exaggerate the signs of menopause (49). Lee admits that there is no empirical evidence that supports this contention, but she does cite research that indicates that for women the negative stereotypes are quite pronounced in our society (50). Lee also argues that some women may be particularly affected by the suggestions and stereotypes of the older woman as asexual. However, there is considerable evidence to show that sexual activity may even be enhanced and become more spontaneous for women in the post-menopausal year when they no longer have to worry about an unwanted pregnancy. Though declining interest in sex has been associated with lower levels of estrogen, Lee points to research that argues that sex is more closely linked to an individual's attitude and to social conditions and not to hormone levels (Lee 50).

PART IV - Hormone Therapy (HT): Debate and Discussion

Please read, Santoro, DeSoto and Lee, "Hormone Therapy and Menopause."

Kate Hunt, in "A 'Cure for all Ills'?: Constructions of the Menopause and the Chequered Fortunes of Hormone Therapy," provides the essential debate that has informed discussion on the credibility of HT for the past few decades. She states "the provision of hormones to "replace" those "lost" after the menopause is the embodiment of the medicalization of menopause" (141). Whether women should take the hormone estrogen, or estrogen combined with progestin, has been a vehemently debated women's health issue leaving many mid-life women wondering just what to do. HT claimed to protect women against two of the most common diseases associated with old age: osteoporosis and heart disease. However, many researchers questioned this notion by arguing that data supporting this claim was incomplete. They also pointed to that evidence that argued that an increase in cancer was evident in women who took hormones in the post-menopausal years. The Hunt article is actually now outdated having been supplanted by research from the Women's Health Initiative which appears to have finally provided the answers to this difficult question, at least in terms of the combined estrogen/progestin hormone treatment.

The degree to which the signs of menopause have either short term or long term health consequences for women varies greatly. Certainly aging itself has health outcomes for women and men, but this too varies widely and is often associated with the factors that determine health in the first place. Exactly what health issues—heart disease, cancer, Alzheimer's disease—are associated with old age or what are the effects of menopause is still unclear. The widespread use of HT was based on the assumption that menopause causes women to have a hormone deficiency or a "deficiency disease." Even though some women might benefit from taking HT to relieve hot flushes and night sweats, Davis argues that only about half the women who take the drug actually do report improvement or a reduction in these signs (Davis 69). There is also data to support the contention that women at risk for osteoporosis and colon cancer could benefit from HT. The most recent research suggests that the risks of HT far outweigh the benefits. In fact, the medicalization of menopause has been shown to do more harm than good.

As discussed in an earlier unit, medicalization refers to making a normal process or condition into one that requires medical intervention. The change begins with medical professionals but must be accepted by society in order for the process of medicalization to be complete. With respect to HT, both are evident. HT was prescribed by medical professional to millions of women worldwide (Li 101). A Finnish study cited in Lee shows that the use of HT increased five times between 1976 and 1989 (47).

In 1986 Bell and Oudshoorn challenged the widely held assumption that drugs are tested and their purpose defined before reaching the marketplace (Li 101). Robert Wilson's book *Forever Feminine* (1966), the publication of which was heavily funded by the pharmaceutical industry, did more than anything before it to define menopause as a "deficiency disease." His book "promoted estrogen as a way to smooth out the physical and psychic bumps of the "change of life" (Li 102). Woman, Wilson claimed, have "outlived her ovaries and therefore her biological usefulness" (Li 101). Wilson was not alone is his view of the menopausal women. In fact many physicians still see menopause as a deficiency disease. In 1994 Dr. Roger P. Smith claimed that "more and more we are coming to view menopause not as the "natural process" we

once considered it, but rather as an organ failure." That same year Dr. Rogerio Lobo said that "although menopause is a natural event, the age of menopause has not changed, [but] life expectancy has markedly increased. Therefore, it is perhaps not "natural" for women to be living longer" (www.inorm.org/sense.html).

Drugs such as Premarin, one of the most widely used forms of estrogen replacement therapy (ERT) was prescribed to women by the medical profession who embraced the concept of curing women of what many refer to as the disease of aging. When it was discovered that estrogen alone caused cancer of the uterus sales dropped dramatically (Mitchell).The addition of progestin to estrogen, (resulting in combination hormone therapy as opposed to estrogen replacement therapy) ended the fear of cancer of the uterus and the drug was once again in favour. In 1994 the Society of Obstetricians and Gynecologists of Canada recommended that all menopausal women take HT for at least ten years, regardless of whether or not they showed any of the signs of menopause.

The use of HT to prevent osteoporosis was the first step away from using hormones to treat the short-term effects of menopause such as hot flushes (Hunt 143). Although there is evidence to suggest that women who take HT do experience a decreased risk of getting the disease, a decline in estrogen is not the only reason for weakening of the bones. If estrogen was the root cause of osteoporosis then it should follow that all women would be subject to the disease since all menstruating women experience menopause. In fact, only about one quarter of women will get osteoporosis. Some women are more vulnerable than others: women with a family history of osteoporosis such as a mother or a sister, thin women, women who went through menopause early (under the age of 45), as well as women who smoke, abuse alcohol, have low calcium intake and those who follow a sedentary lifestyle. It should be kept in mind that bone loss in women begins well before the onset of menopause and long before estrogen levels drop during menopause and yet decline in estrogen has been the focus of attention. Instead of prescribing lifestyle changes for women who are at high risk, all women were encouraged into hormone therapy.

In the 1990s heart disease was added to the list of health problems that HT was supposed to prevent. This was done based on the Nurses Health Study. In this study one hundred and twenty thousand women were followed. Their lifestyle and medical condition were monitored every two years over a period of time. Women who took HT for ten or fewer years reported a lower rate of coronary heart disease. However many feminist health and medical activists and other researchers argued that the results of the Nurses Health Study were suspect since the research was seriously flawed (Mitchell 2003).

For years, feminists and health activists claimed that not only was hormone therapy not necessary for all women, but that some women could potentially suffer life threatening side effects from taking hormones. In the summer of 2002 their suspicions were confirmed. It was discovered that the risks of taking HT far outweigh the benefits at many levels. The data emerged from the Women's Health Initiative. More than 27,000 women between the ages of 50 and 79 participated in a study to consider ways to prevent heart disease, breast and colorectal (colon and rectum) cancer and osteoporosis in postmenopausal women. Participants were to be followed for 8 – 12 years. Some women took the combination therapy of estrogen and progestin (HT); estrogen alone was prescribed to women whose uteri had been removed (in this group there was no concern about cancer of the uterus); a third group was given a placebo, that is, a pill that looks exactly like one of the hormone therapies but actually had no active ingredients (National Institute on Aging 2003).

In July 2002 the Women's Health Initiative stopped the study involving the combined estrogen plus progestin because they found that women taking the combination therapy showed an increase in heart attacks, breast cancer, strokes, and blood clots compared with women taking the placebo. However, they also found fewer hip fractures and less chance of colon cancer in the women on the combined therapy. The portion of the study with women taking estrogen alone was continued. The following provides risks and benefits of the combined therapy:

Risk or Benefit	Absolute Risk Each Year
Heart attacks	7 more cases in 10,000
Breast cancer	8 more cases in 10,000
Strokes	8 more cases in 10,000
Blood clots	18 more cases in 10,000
Hip fractures	5 fewer cases in 10,000
Colon cancer	6 fewer cases in 10,000

One of the problems with prescribing drugs to keep people healthy is that a dependency on the drug can be created. Thus, instead of individuals becoming empowered to care for their own bodies they become dependent on the medical system for a cure.

Life style changes will go a long way to keep hearts healthy and bones strong. An editorial by Dr. David Sackett in the *Journal of the American Medical Association* in July 2002 at the time that the HT study was stopped said that "the commonly held belief that aging routinely requires pharmacological management has unfortunately led to neglect of diet and lifestyle as the primary means of achieving healthy aging. Are we medicalizing too many symptomless disorders and symptomless people"? Sackett feels that we are. "Millions of women," he argues, "were prescribed medication on a promise that it would not only alleviate the signs of menopause but improve the health of their hearts. Dozens or hundreds who would have otherwise remained healthy may have died as a result" (Sackett 2002).

✍ IDEAS TO REFLECT ON

The article by Elizabeth Santoro, et al and referred to above reiterates many of the points developed in this section of the unit. As you read the article consider the following questions:

1. What does the research say about "replacing" the hormones women lose as they age?
2. What are some of the reasons why HT may be prescribed to women?
3. What did the Women's Health Initiate Memory Study find regarding Alzheimer's Disease and other forms of dementia?

DEMEDICALIZING MENOPAUSE

Please read, Allina and Fugh-Berman, "Natural Hormones: Are They a Safe Alternative?

Are their ways that women can take control of their well-being through the menopausal experience? Certainly, as noted above, some women will have severe signs of menopause and should discuss these with their medical practitioner. Since HT has been shown to reduce the impact of menopausal sensations, they may choose, after consulting with their medical practitioner to use the drug. If they decide on HT, the message to them is to take the lowest dose for the shortest period of time. Before seeing their medical practitioner they should do their own research on menopause and HT so that when they talk to their care provider they are well informed and can ask informed questions. Local book stores have resources that deal with life-style changes and that discuss the latest findings with respect to HT. The internet is also another source for information. Publicly funded web sites such as the Canadian Women's Health Network sponsored by Health Canada will provide guidance and is linked to other informative websites. However, a woman's health practitioner should always be consulted and if a non-hormonal alternative is chosen and she should consult her health practitioners regarding how that treatment may, or may not, conflict with any other medications she may be taking.

There are many ways besides using drugs to cope with the signs of menopause. Many women find that changes to their diets are beneficial; others used physical activity to distract from the sensations of menopause. In fact, the most frequent coping strategy used by women was exercise. The positive effects of exercise to alleviate the signs of menopause are well documented. According to Lee there are many health benefits from exercise that overlap with what was expected of HT. For example, exercise helps to prevent heart disease, improves bone density, and can even relieve hot flushes. Exercise will also help alleviate sleep problems. As well, the data shows that exercise positively affects depression, anxiety, self-esteem and general mood. Older women often fall into a sedentary lifestyle. Getting out and exercising can draw women into a circle of people who can provide them with ideas about how to deal with the issues of midlife and beyond. The social benefits can also be health enhancing. Lee holds out the possibility that lifelong medication can be avoided by women who adopt positive health habits during the mid-life years through diet and exercise. However, older women would also experience a more positive menopause and post menopause period if they knew that they had financial security in old age, could depend on comfortable and affordable accommodation and knew that they were safe from violence.

Certainly diet can also help. Many women report that avoiding hot or spicy food, caffeine and hot beverages may improve both the severity and frequency of their symptoms. Dietary supplements are also popular with some women who claim that they work for them. There is little research available to know whether dietary supplements make much difference in controlling night sweats and hot flashes. Isoflavone supplements such as soy and red clover, black cohosh and Vitamin E have all been used with varying degrees of suggest. These should only be used in consultation with your health practitioner (Shapiro L9). For example, Health Canada is warning women about black cohosh advising that there is a potential link between health products containing black cohosh and liver damage (www.cbc.ca/consumer/recalls/2006). Judging the safety and effectiveness of any herbal remedy is difficult in light of the lack of standardization and regulation of herbal products (Youngkin and Isreal 1996).

Many women look to the so called "bio-identical" hormones, that is, artificial hormones made from plant matter such as soybeans or yams, and chemically identical to hormones produced by the ovaries. These are available in well-tested prescription drugs such as estrace (which belongs to the class of medications known as estrogen replacement therapy) along with estrogen skin patches and topical gels. However, bio-identical hormones were not part of the study undertaken by the Women's Health Initiative so we cannot speculate on their long-term safety.

Some women continue to look to the "bio-identifical" or natural hormones, as safe alternatives to prescription hormones, that is, chemically altered hormones that have estrogen-like effects.* In the reading from The Canadian Women's Health Network, by Allina and Fugh-Berman asks, are natural hormones safe? the point the authors make is that "products are not necessarily safe just because they're natural." In fact they argue that the same questions that we ask about drugs need to be answered for natural therapies such as why are we taking it? Is it effective for what it is recommended for? and What risks are associated with it? The authors outline some of what is known about the safety and efficacy of a few of the alternative therapies promoted to relieve the signs of menopause.

✍ IDEAS TO REFLECT ON

While reading the article by Allina and Fugh-Berman consider the following:

1. Why should women be sceptical of "natural" hormone products?
2. Why is little money spent on assessing the value of natural hormones?
3. "Although derived from a plant, it is a stretch to consider natural progesterone a herbal product" (193). In the opinion of the authors, what is the problems with natural progesterone?
4. After reading about what we know about DHEA, Estroil and Tri-Est(rogen), Melatonin and Natural progesterone, identify the problems with these therapies that have been uncovered by researchers that should cause women to stop and think before using them.

A final note

This unit has suggested that menstruation and menopause are normal cycles in women's life. For some time these natural events have been medicalized and viewed negatively in terms of their impact on women's health. Most women appear to favour a self-help approach that empowers them as they assume responsibility to inform themselves of what is taking place in their bodies at each cycle of change. Certainly, some women's discomforts must be treated medically, but such women are vastly in the minority. However, even with those women who must seek medical help, being informed and participating in the decisions regarding their treatment can be empowering.

* Prescription or synthetic, chemically altered hormones having estrogen-like effects. Drug companies take a real hormone (in the case of Premarin, from horse urine!), alter its chemical structure in a laboratory, mass produce as "estrogen" (www.1.menopause.com).