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# Communicating change: An ethnography of women's sensemaking on menopause, hormone replacement therapies, and the Women's Health Initiative

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Communicating Change:  
An Ethnography of Women's Sensemaking  
on Menopause, Hormone Replacement Therapies,  
and the Women's Health Initiative

by

Linda Vangelis

A dissertation submitted in partial fulfillment  
of the requirements for the degree of  
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ABSTRACT

As a result of the recent findings of the Women's Health Initiative (WHI), many women who have been on hormone replacement therapies (HRT) have begun to renegotiate their understandings and strategies of this stage of their lives. The WHI findings suggested that the risks of HRT outweighed the benefits for healthy menopausal women. This study examined women's emerging sensemaking regarding HRT and menopause in light of the WHI findings.

Seven women in the Tampa Bay area, who were in various stages of menopause, participated in three focus group sessions and two one-on-one interviews to discuss their lives in menopause. Based upon the women's conversations, I constructed individual stories about each of the women. I included my voice in each step of the process, both participating in the focus group and interview discussions and inserting my voice in the women's stories as an interview and focus group participant. I analyzed the stories to determine categories in the women's emerging sensemaking. A theme of change emerged in terms of loss, decay, and decline. The women talked about change while discussing personal issues such as children, their bodies, aging, health concerns, and sex.

Throughout their discussions, the women spoke about the contradictions and dilemmas they faced as they tried to sort through the conflicting and sometimes contradictory information they have been receiving about the effects of menopause and HRT on their bodies. Emily Martin's medical metaphors, Michel Foucault's ideas on discourse, and Watzlawick, Weakland, and Fisch's theory of change helped me understand the women's sensemaking. Many of the women framed their sensemaking within the biomedical model of health care, using what Martin called the body-as-machine metaphor, thereby making a first-order change, even though they changed from one HRT formula to another, from "synthetic" to "natural" HRT, or stopped taking HRT entirely. One woman appeared to make a second-order change. Overall, the women felt they had little to guide them as they determined how to take care of themselves in the menopausal stage of their lives.

## PREFACE

This research project is the culmination of a personal journey that began when I first discovered I was entering menopause. In our society, women are labeled young and vibrant until they approach menopause. But once a woman enters menopause, she is no longer considered a “productive” member in our society. She can no longer function as a baby-making machine. Hence, she no longer has social capital to trade. She is considered over-the-hill, a has-been, an old crone, or just plain old. Many times the mature, menopausal woman becomes invisible at this stage in her life. So, I set out to talk with women about their experiences of menopause. In the following pages, I attempt to make sense of the dizzying array of issues that surround women in menopause in our society. I share my journey with you through my personal stories and through the stories that I heard from other women.



## PRELUDE

### Moment One . . . The Shock

An intake nurse at the Student Health Center escorts me into a small, windowless office decorated with several pictures of children. I guess her age to be somewhere in the late fifties or early sixties, based upon her silvered hair and lined face. Dressed in a traditional, white nurse's uniform, with a gray sweater covering her shoulders, she offers me a seat adjacent to the side of her desk, and sits down in her chair. Facing me with alert blue eyes, she waits for me to explain the reason for my visit today.

"I must be coming down with something. Maybe it's the flu," I sputter, trying to keep my voice calm. "I feel as if I have a temperature, and have felt this way for about two months now, but I never seem to get sick. I've taken my temperature a thousand times, but it's always 98.7. And I'm taking aspirin regularly, just to head off the bug I must have caught." My voice quivers.

The nurse nods and offers me a smile of encouragement. I suck in a deep breath to regain my composure and scoot closer to the edge of my seat to face her more directly. My voice begins to rise with my rising frustration, and my words shoot out machine gun style.

"I'm really worried because I wake up in the middle of the night and my hair and nightclothes are completely drenched. I think I might be really sick. Aren't night sweats

an indication that something has gone wrong with my body? Aren't night sweats an indication of a serious illness?"

A surge of warmth swells through my body. The room has been blasted with 100-degree heat; at least that's how I experience it. I try my best to hold back the tears welling in my eyes, but they spill down my cheeks, and I begin to sob. The nurse offers me a tissue and smiles sympathetically. I dab my eyes and smooth a lock of hair off my forehead before I continue.

"I don't know why I cry so much." As a way to soothe myself between sobs, and to reassure the nurse that I'm not weird, I explain, "I'm really okay. Honestly, I am. I just can't seem to stop crying these days." My shoulders heave up and down, and I try unsuccessfully to take a deep breath to short circuit my sobs. "And I cry for the littlest reason. Like, if anyone stares at me with a stern look on their face, I'll burst into tears." Still weeping, but worried that she will think that I'm crazy, I explain again, "I'm okay, honestly. I'm just a little emotional these days. I'm actually an emotional person by nature." I wipe the tears from my face, and make short sniffing sounds as I try to stifle the sobs that have welled up inside of me again.

The nurse hesitates for a moment, and gives me a reassuring nod. I can see by her empathic smile that she does not think that I'm crazy.

"You're 50 years old now, Linda" she says calmly, "and at the right age to be going through menopause. You are describing classic symptoms of menopause. We need to get you in to see the gynecologist. She can prescribe hormone replacement therapy for those hot flashes that you have been experiencing."

I am surprised to hear these words. This is the first time that my identity has been connected to the words “menopause” and “hot flashes.” A swirl of conflicting thoughts and feelings flood my mind, while I try to take in the meaning of her words. I am startled to have been labeled menopausal, yet I am relieved to have a label to go with my symptoms. I am also stunned by the sudden realization that my understanding of who I am has suddenly shifted with her words.

#### Moment Two . . . The Biomedical Quagmire

Several weeks later, I meet with Marsha, a nurse practitioner. She is trim and youthful looking, in her mid-forties and very petite. She is dressed in a stylish slacks outfit. Compared to her, I feel fat and out of style in my size extra-large baggy sweats. We chat for a few minutes before beginning the examination. As Marsha talks, heat rises up from deep within my chest, and spreads quickly through my body out to the tips of my fingers and toes. I bite the inside of my lower lip in an attempt to keep myself composed. But finally, I can't hold back, and tears slowly cascade down my cheeks.

"Something is going on with my body. I alternate from getting hot and cold, and am so emotional." My voice quivers. I blot my tears with a tissue and take in a deep breath. "And I'm concerned because sometimes I have to work really hard to stay focused." I dab my eyes again. "I have never had a problem in the past focusing." I gasp softly, taking in a breath of air. My chest heaves up and down as I try to squelch my sobs.

"Yep, I'm pretty sure that you are perimenopausal, Linda," she responds sympathetically. You are at the right age and your symptoms are very normal. We'll do a routine gynecological examination today, and I'll give you a prescription for a

mammogram. When we're finished, we'll talk about putting you on hormone replacement therapy. Of course I'll need to see the results of your lab work before you can begin taking hormones. And we'll test your Follicle Stimulating Hormone (FSH) level to see if it is still within the normal range. That will tell us whether you are perimenopausal or going into menopause. Since you are getting regular periods, I suspect you are perimenopausal."

I nod in agreement, but I keep my real response hidden.

*I'm not sure I want to take hormone therapy right now or ever.*

*I don't like taking any medicine unless it's absolutely necessary.*

*I'm worried about ingesting something that may increase my chances for strokes, breast cancer, or other complications.*

*I'm nice and healthy, but what if taking this medicine hurts me in the long term.*

*How will I pay for medicine on my meager budget?*

A flash of heat courses through my body at lightening speed. Tears fill my eyes.

*I'm so embarrassed at crying so easily.*

*I feel like a big baby.*

*She must think I'm crazy or off balance.*

*You're going to be okay, Linda, just hang on.*

Marsha sits on the lower rung of the examination chair, facing me, with her legs crossed and tucked up under her. She looks like a youngster, sitting curled up, and I notice that she has positioned herself in a non-threatening manner. "Taking hormone therapy will put your ovaries to sleep," she calmly explains. The hormone medication will do the job of your ovaries."

My mind leaps into high gear, like a car engine shifting from 0 to 60.

*It sounds as if I'm performing an act of mercy on my ovaries.*

*I'm afraid I'll destroy them with the hormone medicine.*

*I'm afraid to take medication unless I'm really sick.*

*I'm not equipped to make this decision right now.*

*Oh, no, I haven't thought this through yet.*

I force myself to stop my thoughts and pause for a moment with the promise that I don't have to take the medicine if I don't want to.

"But does that mean that my ovaries won't work any longer? I ask. "For example, what happens if I decide to go off the medication? Will my ovaries begin to work again, or will they be unable to function?"

An intense surge of heat shoots through my body like a bolt of lightning.

*What if the hormone therapy closes down my ovaries permanently, or causes them to atrophy prematurely.*

*What if taking this medicine shuts down my normal menstrual processes prematurely.*

*I do not want to fool around with my hormone levels.*

"Linda, I want you to know that I have been on estrogen replacement therapy for a few years now. I feel great! I don't get hot flashes any longer, and my husband appreciates the fact that my moods don't swing wildly either!"

*I am shocked to hear that she is on hormone therapy.*

*She looks so young and trim and calm.*

*She couldn't possibly be suffering from hot flashes.*

*She is so calm and relaxed.*

Marsha reassures me that I too will begin to feel great, and that hormone replacement therapy should eliminate my hot flashes and mood swings. She says that once I am on estrogen, I should begin to feel like my old self in a few days.

*It would be great to feel like my old self again.*

*I would feel strong and vibrant and independent again, able to handle problems without shedding a tear.*

*I would have my energy level back, and never feel fuzzy-minded.*

*I won't cry at the drop of a hat.*

*I'll have control over my life again.*

*Ah, it would be great to feel like my old self again.*

*But, I don't understand what effects the hormone therapy would have on my body in the long term.*

I leave Marsha's office with a prescription for Prempro and a promise to her that I will fill the prescription if I continue to feel too uncomfortable.

## CHAPTER ONE

### MENOPAUSE

#### In Good Health

“Dr. Lee!” a heavy-set woman calls out. “I have just one question for you.”

The forty-something woman bounds towards our table, smiling broadly at the white-haired man in a conservative, black business suit sitting to my right. She is clutching a copy of his latest book on breast cancer (Lee, Zava, & Hopkins, 2002) close to her chest. Stopping directly in front of him, she pauses, waiting for him to acknowledge her. Her outburst momentarily breaks my concentration, and I look up to see a group of women jockeying for position behind the heavy-set woman. They quickly cue up in a haphazard line that begins to snake around the perimeter of the large convention room. I can't see the end of the line from my vantage point sitting next to Dr. Lee at a small table covered in a crisp, white table cloth, in the lobby of the Crosstown Church in Brandon, Florida. Dr. Lee is a well-known proponent of using progesterone cream to stay healthy during menopause and as a replacement for synthetic forms of hormone replacement therapy to help alleviate menopausal symptoms. I have come here today to hear him speak. I pull my attention back to our private conversation.

“So,” Dr. Lee continues, staring directly into my eyes. “When they draw your blood, they spin it down in a centrifuge and all the water goes to one end and all the fat goes to the other, and then they look in the water end. Isn't that amazing!” His eyes

twinkle. I am surprised at how sharp and alert he appears to be for a man in his early eighties.

“Okay!” the heavy-set woman interrupts again. She scoots so close to the front of our table that she is almost leaning against it. She pauses for a just moment before plunging into her story. “I had a hysterectomy last year and –”

“You had a what?” demands the doctor, curtly, stopping her in mid-sentence.

“I had a hysterectomy last year,” she starts again, only softer this time. She offers him her copy of his book, as if to bridge the tension that seems to have formed between them.

“Why?” he inquires, his brow beginning to crease. He accepts the book, pulls open the front cover, and begins to scrawl on the clean, white page. He confides to me that he would like to learn how to write the words “good health,” in Greek, since Greece was the beginning of medicine. But today, he writes these words in English, signs his name underneath the message, and returns the autographed book to the heavy-set woman.

“They said I had a growth there, whatever, so they took my uterus out,” the heavy-set woman explains.

“Now, when you say hysterectomy, do you mean removal of the uterus?” he asks, smiling up at her.

“Everything,” she explains.

“No! No! Hyster is Greek for uterus. There is no other meaning. If he removed your nose, or your left ear, or your toe, or your appendix, or the ovaries, he’s doing something else. Hyster is Greek for the uterus, period! The man is an idiot,” he shouts at her.



“She,” the heavy-set woman quietly corrects him.

“She doesn’t have the balls, the guts, to say ‘and by the way I castrated you too.’

They took away your ovaries and the ovaries make three different kinds of estrogen.

They make testosterone, they make progesterone, and of all those, what did they give you back after taking it away?” he scowls at her.

Tears well up in the woman’s eyes. Her lower lip begins to quiver. Yet she continues to ask him questions about the estrogen that she is currently taking. She wants to know if she should continue taking it. While they talk, I wonder to myself why he is so angry and why he would talk to her in this way, since she had had the hysterectomy such a long time ago. And I am startled to hear her ask him for personal medical advice in this open environment, especially as Dr. Lee has not been a practicing physician for over fifteen years.

“All right, so when they give the estrogen, it’s just like the farmers giving estrogen to steers,” he explains to her. “Steers have been castrated too, just like you were. And guess what? They give the steers estrogen and do you know why? It makes them fat!”

“It makes them fat?” she repeats, innocently.

“So they get to be market weight sooner, less time, less money, less feed, less everything. Isn’t that amazing. All the farmers know it, and your doctor doesn’t know it. He is giving you medicine that prevents you from burning fat. You cannot burn fat for fuel.” He sounds agitated.

“So, I can get off of that is what you’re saying?” she asks.

“Of course.” He concedes. “You are a factory of fat right now.” “Do you understand what is happening?” He turns to me. “It’s a crisis and look what is happening! And [her physician] is going to keep on doing this until she creates a problem that kills this lady. It’s gonna create breast cancer, gonna create strokes, gonna create heart trouble, gonna create God knows what! It’s a terrible thing. Mother nature never, never, never wanted humans to only be taking estrogen.”

The heavy-set woman bows her head and moves aside, clutching her signed copy of Dr. Lee’s book. The line of women inches forward slowly, each taking her turn at the table.

“Dr. Lee, I developed asthma when my estrogen went to zero. They put me on Premarin. Is that at all coincidental?” a woman asks staring at him earnestly.

“My progesterone level was at 11,509!” another woman confides to him.

“My mother had a hysterectomy. Can she do without estrogen completely?” a woman inquires.

“For a few years I have suffered with the swings and the crying and the hot sweats, once an hour, for two minutes in length.” another woman confesses.

“My daughter has been on oral hormones. Would you recommend a compound for her?”

“Where can I go to have a saliva test?” another woman asks.

Dr. Lee fields the women’s questions until, finally, it is time for his lecture to begin.

## The Problem with Hormone Replacement Therapy

Each day approximately 3,500 women in the United States enter menopause (“Vital Stats,” 2002, p. 176). As women enter this stage of their lives, they may experience uncomfortable symptoms associated with menopause, such as night sweats, hot flashes, and mood swings. Until recently, hormone replacement therapy<sup>1</sup> (HRT) was the conventional, recommended therapy used to control these uncomfortable symptoms and to head off certain diseases associated with the loss of estrogen, such as osteoporosis. For a time, HRT appeared to be a panacea for the older woman. It was heralded as a vehicle that could help a woman maintain her youth, beauty, and health. Most healthy menopausal women were encouraged by their physicians to use HRT (Masse & Legare, 2001, p. 51). But the recent findings of the Women’s Health Initiative (WHI) have forced many women to revisit their understanding of HRT and to reconsider their decision to take HRT to stay healthy in their older years. The WHI found that giving HRT to healthy, menopausal women may do more harm than good (Writing Group for the Women’s Health Initiative Investigators, 2002). This research study found that HRT increased a woman’s risk of developing breast cancer, heart disease, and circulatory disorders (Writing Group for the Women’s Health Initiative Investigators, 2002).<sup>2</sup>

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<sup>1</sup> Hormone replacement therapy (HRT) is used to augment a woman’s natural levels of estrogen and/or progesterone with either a synthetic or bio-identical form of estrogen and/or progesterone. Recently, the National Institutes of Health’s website has used the terms *menopausal hormone therapy* and *postmenopausal hormone therapy* in place of the term hormone replacement therapy (“Facts about Menopausal Hormone Therapy,” n.d.). In this study, I have retained the original term, hormone replacement therapy or HRT, as my participants used this term in their discussions.

<sup>2</sup> The Women’s Health Initiative is a large-scale, longitudinal, national health study of postmenopausal women between the ages of 50 and 79. This study sought to examine the most common causes of several chronic diseases in postmenopausal women, such as cardiovascular disease, cancer, and osteoporosis. Two randomized, clinical trials of hormone therapy were components of this study. One of the hormone trials examined the health effects of the use of estrogen plus progestin among healthy postmenopausal women.

Since the first release of the WHI findings in early July of 2002, mainstream information in the news media on menopause and HRT has been conflicting and very confusing. Some articles have reported on the dangers of HRT, explaining that the benefits of HRT have been overrated (“Study,” 2003, pp. 1A, 4A; “FDA,” 2003, p. 13A) and that HRT does nothing to help most women cope with menopausal symptoms (Stein, 2003, p. 4). Other articles have warned that it is important for women to take estrogen after menopause in order to stay healthy, explaining that premenopausal women hardly ever have heart attacks, but postmenopausal women, whose hearts are no longer protected by estrogen, quickly become more vulnerable than men to heart attacks (Gupta, 2003, p. 84). Yet other articles explain that taking HRT doubles the risk of a heart attack during the first year of therapy (Duenwald, 2003, p.10). Some articles have touted the benefits of taking lower doses of HRT, which appear to provide menopausal women with the same benefits as the higher doses of HRT (Minkin, 2002, p. 168). And yet other articles have touted the benefits of taking “natural” or plant-based formulas of HRT rather than synthetic hormone replacement therapies (Aschoff, 2003, p. 3D).

What is a menopausal woman to do? Women who are interested in staying abreast of the latest information on menopause, HRT, and health are having a difficult time navigating the quagmire of medical contradictions and competing claims available today. Coping with menopause and its related symptoms has become confusing for any

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This trial was halted in July 2002 after 5.2 years of follow-up because the overall health risks to participants exceeded the benefits. Research found an increase in coronary heart disease, stroke, and venous thromboembolic disease among the treatment group (Writing Group for the Women’s Health Initiative Investigators, 2002). The second trial examined the effects of estrogen alone on women whose uteruses had been removed. This trial was halted at the end of February 2004 because of an increased risk of stroke among the women taking estrogen compared with the placebo (Writing Group for the Women’s Health Initiative Investigators, 2004). For a readable explanation of this study and its results written for a lay audience, see “Facts about Menopausal Hormone Therapy” (n.d.).

woman who is interested in relieving her menopausal symptoms, yet hoping to stay healthy into her old age. Thus, it is difficult being a menopausal woman in America today, especially if you are one of the 14 million women who have been on HRT (Okie, 2002, p. 1).

How can we keep our bodies healthy in light of the results of the Women's Health Initiative? What long-term dangers lurk within those HRT remedies? Is there any real difference between "natural" and "synthetic" formulas of HRT? And whom can we believe? These are just a few of the many issues menopausal women grapple with today, while navigating the menopausal stage of their lives.

The existing research on women in menopause and HRT explores several themes. One key area of research frames the menopausal woman as a body in distress. The woman's body in menopause has been constructed as in decay, decline, and disease (Daly, 1995; Gannon, 1998; Guillemin, 2000; Klein & Dumble, 1994; Martin, 1992) or sick, aging, and old (Gullett, 1994). This line of research, following what is termed the "biomedical model" of health care, has been the predominant paradigm framing women's sensemaking on menopause. The biomedical perspective frames menopause as a deficiency disease caused by diminishing levels of estrogen (Gonyea, 1996; Hunter, 1996; Shore, 1999). Negative changes such as hot flushes, night sweats, headaches, and increased weight have been associated with menopause. Gannon (1998) includes other negative symptoms associated with menopause:

Dryness and thinning of the vaginal walls, increased incidence of vaginal infections, loss of breast firmness, dizziness, sensations of cold in the hands and feet, irritability, depression, insomnia, pruritus of the sexual organs, constipation,

atherosclerosis, osteoporosis, and incontinence have traditionally been attributed to hormonal changes associated with menopause and have been assumed to be effectively treated with hormonal replacement therapy. (p. 289)

The biomedical perspective encourages women to treat their estrogen deficiency symptoms with medicine, either estrogen alone for women without a uterus, or with both estrogen and progesterone for women with a uterus. But women who frame menopause within the biomedical paradigm and view menopause as a medical disorder have a tendency to develop more negative attitudes toward menopause, which may lead them to have a more negative menopausal experience (Gannon & Ekstrom, 1993). They may also become more fearful about their health and well-being during menopause and beyond (Hunter, 1996, p. 119).

Various news media have been the primary source of information about HRT for most women (Griffiths, 1999, p. 473), but the media appear to convey a relatively limited perspective on menopause, generally describing menopause as a negative experience, as a disease in need of medical treatment (Gannon & Stevens, 1998, p. 1). So, the limited perspective available through the news media may also serve to encourage women to accept the biomedical paradigm.

Feminists have argued that the biomedical paradigm of menopause, which frames menopause as a sex-related, endocrine deficiency disease, disempowers women in a number of ways. First, it medicalizes a woman's normal aging process, ensuring that an entire population of healthy women will be medicated throughout the second half of their lives (Gonyea, 1996, p. 416). Second, it leaves menopausally-ill women disadvantaged relative to men by defining menopausal women as products of their hormones (Gonyea,

1996, p. 418). Third, it assigns decisions related to women's health to the medical and pharmaceutical community (Gonyea, 1996, p. 418). In fact, women generally perceive the medical community as the "experts" on menopause, deferring to the expert's opinion on whether they should use HRT (Shore, 1999, p. 173). The severity of hot flashes is an important determinant in a woman's decision to use HRT (Walsh, Brown, Rubin, Kagawa, & Grady, 1997, p. 43), but a physician's recommendation is also a powerful determinant in this decision (Finley, Gregg, Solomon, & Gay, 2001, p. 46; Walsh et al., 1997).

The biomedical lexicon surrounding the menopausal women's body serves to construct a negative perspective of aging women in our society (Martin, 2001). Medical metaphors of women's bodies model prevailing capitalist ideologies and social hierarchical structures in our society and serve to frame the way we talk and think about women's bodies in menopause. Medical metaphors, such as "body-as-machine" or "body-as-signal-response-system" (Martin, 2001), serve to define women's bodies as separate from their selves, and position women as passive vessels acted upon or controlled by their own body parts and/or controlled by men using technology to act upon women's bodies.

Although research has discussed how menopause has been framed within the biomedical model, how it affects women's perceptions on aging and women's attitudes towards menopause, the characteristics of women who use HRT, and how the biomedical model serves to disempower women, we have yet to investigate how women are currently coping with and making sense of menopause in light of the current findings of the Women's Health Initiative. This is the area that I explore. In this research study, I

examine how women are negotiating and making sense of the menopausal stage of their lives in light of the recent findings of the Women's Health Initiative research study. In the remainder of this chapter, I review the stages of menopause, explain my research questions, and provide a preview of subsequent chapters.

### Defining Menopause – The Three Stages

Medical literature traditionally labels menopause as a three-stage process in a woman's life: the perimenopausal, menopausal, and the postmenopausal stages.

Perimenopause generally refers to the 15-year transitional period of time when a woman's level of estrogen declines (Huston & Lanka, 1997, p. 4). During this time, a woman's periods may become irregular, either heavier or lighter than normal, or longer or shorter in duration, and she may develop other bodily symptoms such as hot flashes, fragmented sleep, mood swings, short-term memory loss, and unexplained fatigue (Huston & Lanka, 1997, p. 5). A woman is considered to be in menopause when she has not had a period for one full year. Postmenopause refers to the time after menopause. But it is possible for menopausal and postmenopausal women to experience some of the symptoms associated with the perimenopausal stage, except for problems with menstruation.

Although these different definitions mark three stages of the menopausal process, all three stages, perimenopause, menopause, and postmenopause, mark one continuous and very powerful, systemic process of change that occurs in every woman's body. In this study, I include women who are in the various stages of the menopausal process, because sensemaking occurs during all three of these stages.

For example, the perimenopausal woman may encounter a shock or surprise as a



result of the new and unusual physical symptoms she is experiencing. This shock or surprise might push her into a framing dilemma—that is, how to make sense of the new bodily experiences that serve to mark her entry into a vague identity category that indicates that she is getting older. This perimenopausal stage may be a rich environment to explore negotiated sensemaking, as often sensemaking occasions are marked by surprise (Luis, 1980, p. 238).

By the time a woman enters menopause, she may have had the opportunity to negotiate and resolve some of the sensemaking issues that mark this “older woman” stage of her life. But because these women may have been taking HRT for several years, they may be in the throes of panic, grappling with the much publicized findings that HRT may do more harm than good to healthy women over time. These menopausal women may be a rich source of information on how, or whether, HRT served to veil or mute the conversation over the inevitability and naturalness of aging female bodies.

The women in the postmenopausal stage may also be a uniquely rich group with which to explore negotiated sensemaking in light of the findings of the Women’s Health Initiative, because these women will have had time to reorder and renegotiate their relationships with others and within our culture at large. And, because all sensemaking is retrospective (Weick, 1995, pp. 61-62), women in this end-stage of the menopausal process may have the greatest wealth of knowledge to contribute to our understanding of how women make sense of and reframe their experience negotiating this powerful, systemic process of their lives. These women may have been the most secure in their belief that they could stay safely on HRT for life. These women may now feel a sense of

betrayal by the medical community and by their own bodies, as HRT may have served to delay their acceptance of their aging bodies.

My research project includes women who are, had been, or are thinking about taking some form of hormone therapy, in a synthetic or natural form, to alleviate or ward off some of the real or perceived symptoms related to menopause. This study includes participants who have used synthetic forms of HRT, but it also includes several participants who have been using “natural” remedies such as soy products, custom-designed formulas compounded at a pharmacy, and progesterone cream that has been purchased at a health store.

### Research Questions

The research questions listed below were designed to help me understand women’s sensemaking within several themes: women’s current medical concerns, symptoms and coping strategies of menopause, aging concerns related to menopause, and emotional support of family members. I interview women in various stages of menopause with a view to answering the following research questions:

1. What stories do the women tell about their experiences with menopause?
2. What common themes arise as a result of the women’s stories?
3. How do individual women make sense of the vague and often conflicting information they receive about their menopausal situation?
4. How do the women make sense of their situations in light of the Women’s Health Initiative?
5. How do women come to an understanding of who they are based upon the changes they perceive taking place in their bodies?

6. How does the menopausal woman reconcile with and reassert a renewed positionality in a society that has traditionally coveted and placed higher value on the younger rather than the older woman?

This report of my study is divided into several chapters. In the next chapter, I discuss my research methodology and review some of the problems I encountered during the data gathering stage of my research. In the third chapter, I tell the stories of my participants and embed my own story within theirs, in order to show how my participants and I are making sense of menopause in light of the recent findings of the Women's Health Initiative. Then I analyze the women's sensemaking on menopause, and finally I discuss avenues for future research on this topic.

## CHAPTER TWO

### METHODOLOGY

#### Entering The Conversation

The handwritten sign directing me to the seminar on menopause is barely visible from the street. I slam on the brakes, make a sharp right turn, and with a sigh of resignation, steer my car down the winding road toward my destination, the Crosstown Church. I imagine that this evening might be a bust, another dead end in my search for an angle for my dissertation topic on menopause. So much has been written about menopause that I have been worried over how I will situate myself within this research topic without rehashing what has been done before.

*I'll stay a half-hour, I promise myself, and if I don't like the presentations, or if it's too hot in the meeting hall, I'll simply leave.* My promise seems to alleviate the apprehension I am feeling about this event.

It's an August evening in Brandon, Florida. Cold air is blasting from the air vents of my Ford Escort, but that does little to assuage the waves of heat coursing through my body, one after another, after another, after another. Hot flashes have become so familiar to me that I can no longer remember a day without furnace-like heat radiating from the center of my chest out to the tips of my fingers and down to my toes. I experience hot flashes as wave after wave of intense heat, and estimate that I have at least three flashes an hour, sometimes more. They have become a daily reminder that my body is

transitioning into old age. My intense hot flashes are one of the reasons menopause has become such an interesting topic for me. I am struggling to cope with this uncomfortable stage of my life, and I wonder how other women are managing this life-stage.

I pull into a parking space next to a shiny, black Volvo. A thin, neatly groomed, dark-haired woman is standing at the back of the car unloading large cardboard boxes. I pop a fresh tape into my tape recorder before jumping out of my Escort, and, with a smile on my face, I offer her a cheery greeting, just as she slams another large box to the ground. The box splits open to reveal a familiar book with a purple and white cover. This box is filled with copies of a popular book on menopause written by Dr. Lee (Lee & Hopkins, 1996; Lee, Hanley, & Hopkins, 1999; Lee, Zava, & Hopkins, 2002), a proponent of natural methods of hormone replacement therapy (HRT). I walk up to the woman and introduce myself. I discover that the woman in the black Volvo is named Lela. She tells me that she owns a health food store in Brandon, and suddenly I realize that this is the woman whom I contacted a couple of weeks ago inquiring about a free ticket to this event. She turned me down.

I move quickly to the main entrance to the church and stop to hold the door open for several vendors who are carrying boxes of merchandise. This event was advertised as a forum on the pros and cons of synthetic hormones vs. bio-identical hormones. But I had no idea that it would also serve as a venue for vendors who espouse a “natural” philosophy on HRT to sell their wares.

The main lobby fills quickly with vendors setting up their displays. Participants slowly file into the lobby, and begin to mull around, browsing. I see saliva kits for sale, books on natural methods of menopause, bottles of estrogen creams, progesterone

creams, and other potions designed to help with libido problems. I grab a brochure at a booth that advertises Bill's Prescription Center as a "full service pharmacy and compounding specialists," and scoop up several brochures on anti-aging and pain at Hoye's Natural Pharmacy booth. A green-colored flyer with a list of instructions on using HRT catches my eye. Written in all capital letters, the list instructs the reader on how to make the transition from synthetic to natural forms of HRT:

\*STOP ALL SYNTHETIC HORMONES OVER TWO MONTHS (every other day for the first month, then every three days for the second month.)

\*HAVE SALIVA HORMONE TESTING TO GUIDE REPLACEMENT (estradiol, progesterone, testosterone, DHEA-S, cortisol.)

\*IF NEEDED REPLACE HORMONES WITH A NATURAL, BIOIDENTICAL FORM

\*IN MOST WOMEN ONLY PROGESTERONE NEEDS TO BE REPLACED (Community Forum, 2002)

The instructions go on to explain that soy isoflavones or Black Cohosh can help with menopause, as well as B-complex vitamins, and concludes with a suggested reading list for Dr. Lee's books (Lee & Hopkins, 1996; Lee, Hanley, & Hopkins, 1999; Lee, Zava, & Hopkins, 2002) on perimenopause, menopause, and breast cancer, and another book titled *Adrenal Fatigue*, by Dr. James Wilson (2001).

Terms, many of them unfamiliar to me, are scattered everywhere—at the booths, on an overhead banner advertising this seminar, and in the products being sold, including bio-identical hormones, isoflavones, natural plant sources, wild yams, saliva tests, estriol, estradiol, estrone, testosterone, natural progesterone, DHEA-S, cortisol, adrenal gland,

androstenedione, and on and on. My thoughts swirl with possibilities and connections as I struggle to make sense of these terms, similar to how one might struggle to navigate a first visit to a large and foreign city. I make a mental note to check out this menopause lexicon in the future.

The lobby is now filled to capacity with middle-aged women. Some jostle for a spot near a booth, hoping for a chance to talk with one of the specialists before the seminar begins. Others stand side-by-side with friends, chatting. A row of women are standing shoulder-to-shoulder, bent forward, surveying an array of potions for sale at the long tables in the far corner. I stand in the center of the lobby, listening to the cacophony of female voices clashing and clanging together like cymbals in an orchestra.

I decide to check out the room where the seminar will be held and am surprised to find myself standing in a huge auditorium-like hall filled with hundreds of stationary seats. Women, some of whom are chatting with a friend, already claim some of the seats. Other women milling around, killing time until the seminar begins. A cameraman is setting up video equipment in the center of the room. Two large television screens hang from overhead black steel arms situated on each side of the long stage at the far end of the room. I am amazed at the sophisticated acoustics at this church. This hall can hold 500 people easily.

Suddenly, I realize that this might be the perfect opportunity for me to test out the viability of the topic I am hoping to use for my dissertation research, by asking some of the women if they would be interested in talking with me in the future. I rush back to the lobby and approach a woman who is alone, leaning against a column. I introduce myself as a doctoral student in the Department of Communication at the University of South

Florida, and explain my research project to her. When I ask her if she would be willing to talk with me in the future, she says yes, gives me her name and number without hesitation, and begins to tell me her story about Prempro, explaining that she just took herself off of Prempro because of the recent findings of the Women's Health Initiative.

"Whenever they came out with Prempro, that's when they [the doctor] switched me to that. It's got to be at least five years that I have been on it."

She sounds worried.

"I read that five years is about the break-off point to taking HRT, at least that is what I read in the news lately." I try to soothe her worry.

"But for the last four or five months, I just wanted a boost to my libido, so she put me on Estrotest," says the woman. "Well, Estrotest has been just fine, my hair is thicker."

"What's that?" I ask.

"It's similar to testosterone. It helps your libido. And I could see the difference in it. It was nice, but I don't want to take anything for the rest of my life. But you do take vitamins everyday, so I want to educate myself. Well, we go to the doctors and they give us a pill. We figure it has certain risks with it, but not all the stuff they came out with. [She means the findings of the Women's Health Initiative (WHI)]. I have a prolapsed valve, so I get arrhythmia, and I'm on medication for it, but I've been on the same dosage for years. Lately I'm getting more palpitations."

"Do you exercise?" asks a woman who has joined our conversation.



“I haven’t been lately because of the heat. Usually at lunch I walk a half hour and at night I’ll ride my bike, but not lately because it has been so hot. I still get those night sweats,” says the first woman.

“Oh, those are horrible,” says the second woman.

“Never during the day, never,” says the first. “Why is it at night, and then you wake up freezing. I have to change my pajamas because I am soaking wet. So now I don’t bother with them because I know I’m going to sweat anyway.” Both women laugh before moving on.

I talk with 33 women before the seminar begins, and almost every woman I approach (all but two) is willing to give me her name and phone number. Some of the women also share a part of their stories on menopause, usually complaining about something—weight gain, mood swings, a low libido, fuzzy thinking, or fatigue since entering this stage of their lives. I am surprised at the level of information these women are willing to share with a stranger, but I am also elated to realize that I have a viable dissertation topic.

Over the next six months, during the summer and fall of 2002, I attended six seminars on menopause in the Tampa Bay area. Two were held at the Crosstown Church in Brandon, Florida, and one each at Tampa General Hospital, the Tampa Bay Performing Arts Center, the Marriott Westshore in Tampa, and the Clearwater Harborview Center in Clearwater. At each seminar, I spoke with some of the women and collected names and phone numbers. I tucked my lists away for future use.

I defended my dissertation proposal in early September 2003. Because my proposal explained my methodological plan in detail, I anticipated moving into the data

collection stage of my project quickly. I prepared my IRB application for initial review several weeks after defending my proposal, and expected a quick approval, as my research fit within their low-risk category. Unfortunately, I had overestimated the Board's understanding of qualitative research. Two days after I had submitted my IRB application for initial review, I received an e-mail from their office, informing me that my application had been referred to a full board review. I was invited to attend the next Board meeting, which was scheduled to be held in early November, and was asked to submit a formal response to a list of eight questions about my research project before the next board meeting. This turn of events not only dashed my hopes for moving quickly into my data collection stage but also shut down my ability to work on my research project. The first question on their list was the most worrisome, because it asked me to explain when my data collection process had begun. The IRB had erroneously assumed that I had begun my data collection process when I had secured the names and phone numbers of women while attending the seminars on menopause the previous summer and fall. Over the next few weeks, with a great deal of help from my major professor, we crafted a carefully worded response to each of the IRB questions. In early November 2003, my major professor and I appeared together in front of the full IRB Board and responded to questions. When we left that meeting, we were confident that we had addressed each of the Board's questions to their satisfaction, but two weeks after the Board meeting, I received yet another request from the Board asking me to respond to a number of additional questions. I thought that I would never begin my project. And because it had been over a year since I had compiled the list of potential participants, I had begun to think that my entire list of names might be obsolete. But my major

professor came to the rescue by contacting the Chair of the Board directly and, as a result of their conversation, I was asked to complete one additional task: compile a list of psychologists in the event the women needed to talk to someone during my study. I finally received official notification of the approval of the IRB a few days before the Fall 2003 semester ended. The IRB fiasco had held up my research process for the entire semester, but I was finally ready to begin the data collection stage of my project.<sup>3</sup>

I planned a four-pronged approach to my data collection process. First, I planned to conduct a brief telephone interview using a script to screen female participants for my study, culling potential participants from the lists of names of women that I had gathered at the seminars on menopause. Second, I planned to convene focus groups of women in various stages of menopause. Third, I planned to hold two one-on-one interviews with the women who fit the criteria for the study and agreed to participate in the study. The first interview would be conducted before convening the focus groups and the second interview after the focus groups had been completed. And fourth, I planned to include my voice in each step of the process, while participating in the interviews and focus groups, and through autoethnographic vignettes. I also planned to give each woman a disposable camera and ask her to take pictures of her life in menopause, and return the camera to me for developing. We would talk about the pictures during the final interview.

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<sup>3</sup> Frustrated about what had happened to me and interested in telling my story to my community, my major professor and I submitted a short narrative to the *Journal of Applied Communication Research* for its special issue on experiences with Institutional Review Boards (Dougherty & Kramer, 2005).

## The Telephone Screening Interview

In early January of 2004, I began to work my way through my list of names and phone numbers looking for potential participants to my study. Using a planned telephone script, I asked each woman I spoke with a standardized list of questions about menopause in order to determine whether she would be willing to make the time commitment necessary to participate in my research project. I tape-recorded each conversation, with the woman's consent. The telephone script, contained in Appendix A, provided the woman with a comprehensive overview of the project plan by explaining the nature and scope of my research project, including information on the two required one-on-one interviews, the three required focus groups, and an estimated time commitment necessary to participate in the whole process. At this time, I also collected demographic information about the women, including age, race, and educational level.

I encountered several problems securing participants for my study from the original list of approximately 75 names that I had gathered at the menopause seminars. Some of the phone numbers had been disconnected by the time I called them. Other potential participants turned down my invitation to participate in the telephone interview. When I phoned possible participants, I left messages for them on their answering machines explaining the reason for my call. Only one of these women called me back. I left messages with each of them on three separate occasions before assuming that a woman did not want to talk with me.

I was able to conduct telephone interviews with 30 of the women who were in various stages of menopause in the Tampa Bay area. All of these women said I could use

the information from their telephone interview in my project, whether or not they decided to participate in the full study.

At this stage of the process, my plan was to screen potential participants according to the list of criteria I had established (see Appendix B). Mainly, I wanted to know if they were willing to attend two interviews and three focus groups. If a woman said she was willing to participate in the full study, and agreed to the interview and focus group processes, I invited her into the project. Even though my preliminary list of criteria included screening participants for age, ethnicity, and educational levels to include a diverse range of women in the study, I did not use these criteria due to the limited number of women who were willing to participate in the study. During the telephone interview, I also asked each participant to give me a pseudonym to use in place of her name, so she would remain anonymous.

My original plan called for me to include 8-12 women in the study, so I planned to stop recruiting women via the telephone interview process when I had at least 16 women who were willing to participate. Doing this would ensure that, once the first one-on-one interviews were completed, I had at least 8 to 12 participants. I reasoned that, if by chance all of the women I met face-to-face agreed to be in the study after we had a chance to talk about the study in more detail, I would simply include all 16. Therefore, I was surprised when I barely met my quota. Many of the women I called (53%) did not want to participate in the full study. They had a variety of reasons for not participating, but most of them explained that they had either a personal or work commitment and just couldn't make the 10-hour time commitment necessary for this project. At this point, I was grateful to have found 15 women who agreed to participate in the study.

## The First One-on-One Interview

The next step in the process entailed conducting the first one-on-one interview with each of the 15 women. My objective for this first interview was to establish the groundwork for our relationship. I wanted to get to know a little about each participant and to help her begin to feel comfortable with me. As a result, I decided to conduct our preliminary interview in a casual, open-ended manner. I did, however, have a general plan. (See Appendix C for my plan and list of questions for this interview.) During the first one-on-one interview, I also reviewed the consent form with each participant, obtained her signature on the consent form, and passed out a disposable camera with instructions to take pictures of her life in menopause. I asked each of the women to bring her camera to the first focus group so I could have the film developed before our final interview. My intention was to use their pictures in our final interview to identify areas of their lives that were important to them, and to give us an additional topic of conversation during the final interview.

When I made plans to meet with the women for the first one-on-one interview, I offered to meet them at a location convenient to them. As a result, I met three of the women at a conference room in the Department of Communication at the University of South Florida. I met three of the women at restaurants they selected. I interviewed two of the women at their offices. Six women invited me to their homes. And one woman, who joined the research while she was in town from Wisconsin visiting her daughter, was interviewed at her daughter's home. All of the interviews were tape-recorded.

Holding the interviews in a restaurant proved to be problematic, because the loud background music in restaurants interfered with the quality of my tape recording. For

example, I met one of the participants at the Panera's Restaurant in Carrollwood at 6:00 p.m., after she finished work one evening. I was able to review the consent form with her, which she signed, agreeing to be in the study. But as the noise in the restaurant was too loud for us to conduct a taped interview, we made plans to meet at her home the following week. That interview never took place. I was never able to re-establish contact with her, and after several phone calls and messages, I decided that she had dropped out of the study.

During the first round of interviews, I found two participants unsuitable for the study. One woman stood me up on two occasions, even though I confirmed our appointments. When I finally did meet with her, I noticed that her interpersonal behavior seemed "off." She didn't crack a smile as we talked, she yelled at me for no apparent reason, and generally appeared to be angry. When she revealed to me that she had a short-term memory problem as a result of a car accident, I decided to drop her from the process. I was uncertain whether she would remember to attend the group sessions, and concerned about how she would mix with the other women. I dropped the other woman from my study because she did not seem to be particularly interested in talking about menopause. This left me with a final group of twelve women who agreed to participate in the study. They had been interviewed over the telephone, interviewed a second time in person, and had signed the consent form. These initial one-on-one interviews took anywhere from one to two hours, with one exception. The mother of one of my participants was visiting from Wisconsin when we held our first focus group at that participant's home. Because the mother joined the project the day of our first focus

group, I conducted the preliminary screening interview as well as the initial one-on-one interview and consent process in person before the focus group convened that day.

### The Focus Group Process

I had originally planned to hold six focus group sessions. Because I had asked each of the women to attend at least three sessions, I had thought that six sessions would be enough to allow each woman room to select three sessions. But this goal proved to be unrealistic. In order to accommodate each of the participant's schedules and to ensure that each of them attended three focus groups, I held eight focus group sessions over a span of one month, during March 2004. It took quite a bit of coordinating and many phone calls in order to schedule the women into the focus groups. But this process worked out nicely.

I held three of the focus groups on consecutive Sunday mornings, in a conference room in the Department of Communication at the University of South Florida. The same four participants attended all three of the Sunday focus groups. (When I discuss this particular set of focus groups, I'll identify this one as the "Sunday" group). I held another three focus groups in the home of one of the participants who lived in south Tampa. Two of these meetings were held on subsequent Mondays, but the third interview was held on a Thursday. The number of participants varied from session to session, with a high of five attending the first session, three attending the second, and four the third session. (When talking about these focus groups, I'll identify them as the "Monday" group.) And I held two additional focus groups, one on Tuesday and one on Wednesday, in a conference room in the Department of Communication at USF. (When talking about these focus groups, I'll identify them as the "Tuesday" group.)



All of the focus groups were held during the day. I had originally planned to hold one series of focus groups in the evening to accommodate the women's work schedules, but this became a moot issue when the women wanted to attend during daytime hours. I brought a variety of pastries, bagels, cheeses, breads, fresh fruits, coffees, teas, and juices to each focus group meeting. All of the focus group sessions were tape-recorded. The time frames for each of the focus group sessions varied from one and a half to two hours. For the most part, the women stayed within the same groups for the entire three sessions, except for one woman who attended five groups. I moved two women from the Monday group to the Wednesday group in order to balance the number of participants and assure at least three per group.

Three women dropped out or were not scheduled into the focus groups. One woman wanted to attend an evening session, but I never convened an evening focus group because the other participants were not interested in attending an evening session, so she was dropped from the study. Another participant appeared to have a scheduling problem, but when I talked with her in more detail about the schedule, she revealed to me that she felt her English wasn't good enough to be understood by the other participants. I tried unsuccessfully to coax her into joining a group. One woman came to one focus group and then dropped out because she had a conflict with her job. These changes left me with a total of nine participants who participated in the preliminary telephone interview, the first one-on-one interview, and three separate focus group sessions.

#### The Final One-on-One Interview

The final one-on-one interviews were held at my apartment in New Tampa during the summer and fall of 2004. I served lunch or dinner at each of these final meetings to

all but one participant who turned down a dinner in favor of tea and pastries. This final interview was by far the most intimate and open conversation that I had with each of the women, including the time we spent talking in the focus groups. I believe that this occurred because I had by this time talked face-to-face with each participant on at least four separate occasions. I incorporated a discussion of the women's pictures in this interview. The final one-on-one interviews lasted from 2 to 3 ½ hours and were tape-recorded. (See Appendix D for a list of questions for the final one-on-one interview.)

I was able to contact each of the participants in order to schedule these final interviews, except for the mother/daughter pair of participants. During the summer and early fall of 2004, I tried several times to contact the daughter, who lived in Tampa, to arrange a final interview with her but was unsuccessful. By early November of 2004, all of the remaining final interviews were completed, so I decided to close down the data collection stage of my research. As a result, two participants were not interviewed during the final round of one-on-one interviews. This left me with seven participants who completed the entire process of interviews and focus groups.

#### The Transcription Process and Issues

Transcribing the myriad tapes I had recorded was a time-consuming process. I had 35 interview events with my participants to transcribe, including 3 interviews for each of the 9 participants (including their initial telephone interview) and a total of 8 focus group sessions. Additionally, I had the tape recordings from the six seminars I attended in the Tampa Bay area. I also had to transcribe an additional 21 telephone interviews from the women who did not participate in my study, but agreed to interview over the telephone. My initial thought was to double space the transcripts, and to include

every sound the women made such as every “um,” “yes,” and other sounds I heard on the tapes as I transcribed them. But doing that became unwieldy, when several of the focus group transcripts ran over 200 pages. During my transcription of the focus groups, I also discovered that the women talked over one another, each forming half-sentences before the other woman would interject her thoughts. So I had overlapping conversations. I tried to incorporate the overlapping conversations when possible, but if the thought was so disjointed as to not make sense when read, I then gathered up the fragments of the thought and pieced them together as a complete sentence where I could. But as I mentioned earlier, I also left some of the half sentences intact, when the flow of conversation was discernable.

During my second pass listening to each of the tapes, I decided to single space the transcripts to reduce the volume of paper to a more manageable level, and I edited the first draft of each transcript to eliminate some of the “ums” and other sounds that didn’t seem to add to the conversation. As a result of these changes, each of the transcripts averaged approximately 55 pages (excluding the telephone interviews). I transcribed some of the tapes myself, but also I enlisted the help of several transcription services to help with the transcription process. Every tape was reviewed twice, either twice by me, if I did the transcription myself, or once by the transcriber and then once by me.

I had to decide what to do with the data I had collected from the women who dropped out during the study. I decided not to transcribe the initial one-on-one interview with the woman who attended only one focus group. I did transcribe the one-on-one interviews with the mother/daughter pair, but decided against writing individual vignettes about any of these three women, because they did not complete the entire process. But,

because one of the women attended one focus group and the mother/daughter pair attended three focus groups, I decided to include their voices in the focus group conversations, as it would be too difficult to eliminate their voices from the flow of conversation. And each of these participants, especially the mother/daughter pair, had contributed actively to the meanings and flow of conversation in the focus groups they attended.

A summary of the demographic information about the nine women who participated in the study is detailed in Appendix E. Included in the demographic information are the three women who attended at least one focus group, but dropped out before the final interview sessions. I also included demographic information about myself, because I participated in the study as a woman in menopause.

### Rationale for My Methodological Strategies

#### *Focus Groups*

Focus groups can be a rich source of information when a people get together to talk about a topic that is important to them (Morgan, 2002, p. 151). Interviews are an appropriate methodology to use when the topic being studied does not revolve around a particular setting, but instead concerns understanding common themes between respondents (Warren, 2002, p. 85). As my research project fit both of these criteria, I decided to incorporate a blend of focus groups and interactive, collaborative, and in-depth interviews when collecting my data. In the next several pages, I first enter into my discussion on focus groups with a brief vignette of my first focus group session; second, I

discuss my rationale for holding unstructured, interactive focus groups and collaborative interviews, and finally I consider some of the pros and cons of these methods.

\* \* \* \* \*

Freshly ground coffee is brewing in the large coffee pot I brought from home, as the women begin to arrive to our first, Sunday morning focus group session. I am in a conference room in the Department of Communication, at the University of South Florida. I came in an hour early, in order to make sure that I had time to prepare the conference room for my very first group. I cover the counter at the far end of the conference room with a white, paper tablecloth, and, as I begin to lay out a breakfast spread, I feel a familiar deep, warmth blast through my body. I continue working, ignoring the beads of perspiration that form on my forehead. I lay out bottles of chilled water, a variety of non-dairy flavored creamers, and a plate of fresh strawberries to go with the pound cake I bought at Sam's Club yesterday. I quickly stack whole wheat and cinnamon-raisin bagels on a plate next to a row of sliced cheese. I wipe my brow and continue working, arranging pink, plastic cups and plates to the far left side of the counter. The women begin to stream into the conference room. They tell me that they could smell the aroma of coffee wafting down the hallway.

We congregate next to the spread of food, chitchatting while we fill our plates.

“Did you see that they stopped the second study?” asks Anna.

“No, I didn't see that. They stopped it?” I respond, startled.

“It was in the paper,” explains Malika.

“Too many strokes,” says Anna. “It's scary.”

“I lost one ovary to a tubule pregnancy, but I still have the other one,” confides Malika. “Before the patches came out they had pellets. They cut my hips every other month and inserted a pellet. I guess they did this for the month I would ovulate from the missing ovary.” She lets out a slight giggle.

We all gasp in reaction to her statement.

*“How could cutting and possible disfigurement happen in the name of HRT?”* I wonder.

*“I never heard of HRT in the form of a pellet. And what does she mean she ovulates every other month? Shouldn’t she ovulate every month, even with one ovary?”* I reason.

I make a mental note to ask a medical doctor about those pellets. Just then, the final woman arrives and we all exchange introductions again. While the women carry their filled plates to the conference table and claim chairs around the table, still chatting to one another, I hurriedly set the steaming pot of coffee onto a trivet at the table and arrange a small container of half-and-half and bowl of sugar next to the coffee pot. I check my microphone and tape recorder one more time to ensure both are working before sinking into an empty chair at the conference table. My heart is racing.

*“Okay, this is it, Linda.”* I think to myself. *“I hope all of my planning pays off. My first focus group session for my dissertation research is about to begin. Whew! I hope I get good data from this session.”*

I take a deep breath. My palms are sweating. I can barely concentrate on the continual stream of conversation I hear from the women sitting around the table. But I am aware that the women have been revealing tidbits of their lives to one another: where

they work, what they do, where they live. My mind is a swirl of competing thoughts. On the one hand, I am marveling at how nicely they are talking together with no prompting from me. But on the other, I am wondering if I should say something formally to start our conversation on menopause.

*“Should I let them just continue talking?”* I ponder this idea.

*“No, that might be too risky. Especially for this session, my first focus group.*

*What if they don’t talk about menopause? Then what would I do?”* I reason.

*“I had better set the stage for our talk today, even though I had hoped to let them just talk about anything today, in a more or less free-flowing, interactive manner with little help from me.”*

I am way too nervous to follow my instincts.

“My daughter is going to be a freshman in college this September,” declares Anna.

I interrupt her to begin my introduction.

“Thank you for being here today,” I begin, breathless with excitement.

In unison, the room goes silent. All eyes turn to face me.

The silence continues.

*“Oh, no,”* I think to myself, staring blankly at the four women. *“I just foiled my plan to test out my new idea for focus group interactions. The women were talking together so nicely before I interrupted them. I just interjected a frame of formality into their conversation. I should not have inserted my authority into their conversation.”* My heart sinks. At this moment I am deeply aware of my inexperience as a researcher. Too late to do anything else, I plunge ahead.

“Essentially, I want you to talk today about your experiences with menopause in light of the recent findings of the Women’s Health Initiative. And I do want to keep the conversation as open and flexible as possible, so that you each have the opportunity to share what ever you want. I really want to hear your opinions with very little prompting from me. So over the next hour and a half, I would like you to share with the group your personal experience in your stage of menopause. Feel free to move the conversation in any direction you want to go. Feel free to share your opinions with the group. I may interject a question just to clarify a response, but as I am also a woman in menopause, I’m going to be interjecting my opinions, too. Would you like a list of questions before we begin?”

I am grateful when the women turn down my offer. Without hesitation, they turn to each other again and begin to chat. I let out a sigh of relief. I have learned my first applied lesson on interactive focus groups; let the conversation emerge with a minimum of help from the researcher.

\* \* \* \* \*

Focus groups are a good methodological choice when the researcher wants to investigate complex behavior and motivations (Morgan & Krueger, 1993, p. 16). Focus groups have also become a prominent tool for giving voice to the marginalized and those outside mainstream society (Morgan, 2002, p. 142). They can be a rich source of information if you have a group of people talking together about a topic that is important to them (p. 151). I had hoped that by using a focus group format the women in my study would share their stories and experiences with one another in the present moment, and provide a rich source of data. And because I had planned on including minority women



and older women in my study, I thought that this methodological choice might also help give voice to those who may have been marginalized or outside of mainstream society. Focus groups “can serve to expose and validate women’s everyday experiences of subjugation and their individual and collective survival and resistance strategies” (Madriz, 2000, p. 836). Focus groups also allow the researcher to observe the interactional processes among participants (p. 836). And as I was hoping to recognize changes in the women’s perspectives on their lives in menopause, focus groups appeared to be an appropriate methodological choice.

When scheduling women into the groups, I didn’t segment them into groups based upon their stage of menopause or age. Rather, I developed a list of dates and times for the various focus groups and asked my participants to self-select the dates most convenient to their schedules. By mixing the women in various stages of menopause, I hoped we would develop a richer interactional process, as the women were sharing different information and experiences.

I conducted the focus groups in an unstructured manner, because focus group participants who are emotionally involved with the topic find it easy to start and maintain a discussion (Morgan, 2002, p. 148). My objective was to allow the participants to reveal their own perspectives and issues regarding menopause. “A less structured approach works best when the participants themselves are just as interested in the topic as the researcher is” (p. 149). Madriz (2000, p. 840) explains that participants in focus groups who are discussing issues that interest them are able to carry on the conversation on their own without any prompting from the moderator. I also planned to join the conversation

as a participant observer, sharing my own stories and experiences on menopause with the women.

But, unfortunately, I did not adhere to my plan. As the previous vignette shows, I panicked when holding my first Sunday focus group and framed the start of the discussion by introducing myself, the study, and encouraging the women to talk freely without a moderator. Unfortunately, during this first focus group session, I also worked into the discussion some of the planned questions I had developed. I did this because it seemed that the women were talking around the topic, and I wanted to ensure that my questions were answered. I was worried that I might not obtain “good data.” Much later, after I had finished transcribing the Sunday tapes, I matched the transcripts to my planned list of questions and discovered that the women answered every question I had thought of asking and went beyond to talk about issues I had not thought to include. Fortunately, I was able to refrain from inserting an initial introduction into the opening sessions of the Monday and Tuesday focus groups and didn’t need my planned questions. I simply started the tape recorder and let the conversation, rules, and roles of the participants emerge. I went along with the flow. This worked well and I followed this plan with the second sessions of all of the groups. During my final (third) focus group sessions with each group, I made a point to ask my planned interview questions to the group of women to ensure that I received answers to the questions I had originally planned and also to give me a benchmark to determine whether I was receiving data that were richer than I might have received if I had only followed my planned interview questions. (See Appendix F for a complete list of planned questions for the focus groups.)

Some problems arose from using an unstructured focus group strategy and sharing my own stories with the group. There is no doubt that I, as the researcher, was framing the sessions. There were the material props, such as the two tape recorders and the microphone sitting in the center of our table during each session. Most of the focus group sessions were held in a relatively formal environment, in a conference room at the University of South Florida, except for the Monday sessions, which were held in the home of a participant in south Tampa. All of these trappings served to frame our work together, and to situate me as the researcher in the eyes of the participants. And as the researcher, I was aware that I was already positioned as an authority figure, but I noticed that the women managed to insert themselves into the group process nicely, including the material processes. For example, they helped with the tape recording process. Sometimes they reminded me that it was time to turn over the tape; other times, they took charge of the tape turning process. And on occasion they would also ask if I had checked to make sure the tape was turned on and recording. After each session, the women would help me pack up my equipment and help me clean up.

And although the women seemed to make a space for me in the conversational process, I wondered how much of this was a result of the power differential between us as researcher-participant. As a result of my curiosity about this issue, during my final one-on-one interview I asked the women what they thought about me joining the conversation. Without exception, they said my active participation in the talk was a positive influence on them. They appreciated that I had joined in the conversation, because it drove home the point for them that this study was an important research project for me (later I discuss the researcher-participant issue further).

However, when I transcribed the Sunday focus groups I found myself groaning every time I heard myself chatting away on the tape, droning on and on about my own hot flashes, the large polyp I had removed from my uterus, my weight problem, and the mystery of my thyroid closing down seemingly in tandem with the onset of severe hot flashes. How boring it was for me to hear myself on tape! I felt that I had taken up precious time talking about myself and found myself wishing I had stopped talking. On the other hand, I also knew that a give-and-take, to-and fro, spontaneous interaction is necessary in order to make space for moments of dialogue (Cissna & Anderson, 1998). And as each set of focus groups had different women in attendance, I was forced to listen to myself happily tell my stories over and over again to the different groups of women.

I tried not to moderate the flow of conversation in the groups, but inserted my voice in the flow of conversation. The women appeared to share the floor with each other, with each having time to express her ideas, except for the mother of one of the participants in the Monday groups. She talked infrequently, with most of her conversation in the form of agreements such as “um” and “ahhh.” One woman in the Monday group did appear to dominate the conversational flow. But the other members of the group seemed to be strong enough to express themselves, especially when sharing a different perspective with the group (Morgan & Krueger, 1993, p. 33). In thinking about the dynamics of the group interactions, I believe that a group leader emerged in the Monday group sessions because I did not lay out ground rules during my initial meeting with that group.

### *Interactive and Collaborative Interviews*

Qualitative interviewing may be viewed as a collaborative process between the interviewer and the interviewee (Ellis, Kiesinger, & Tillmann-Healy, 1997). A collaborative dimension to the interview process was particularly important to my research project, as I had hoped that a more dialogic process would emerge as a result of my interactions with the respondents and that such a collaborative process would set the stage for a richer exchange between me and my research participants. Although genuine dialogue cannot be planned beforehand and must occur spontaneously between the people (Buber, 1998, p. 77), I had hoped that a collaborative interview process would provide the frame for me and my participants to remain open to engage in dialogue, if an occasion were to occur during the interviewing processes.

As I had also hoped to blur the boundaries between the researcher and the subject, I used interactive interviewing as a means to engage in joint sensemaking with my participants. Ellis and Berger (2002) used interactive interviewing successfully, and explain that the collaborative and relational aspects of this interview process aids in the construction of the meanings that emerge from the interview. Interactive interviewing also helps the researcher obtain a more intimate understanding of people's experience and is good to use when working with emotionally charged and intimate topics (Ellis et al., 1997, p. 121). Interactive interviewing works best in small groups, and when the researcher has personal experience with the topic. The goal of this type of interview process is for the researcher to act as both researcher and research participant. Interactive interviewing usually requires multiple interviews and requires that the researcher and participant develop a relationship so that the researcher and participant engage in joint

sensemaking (Ellis et al., 1997, p. 121). Although interactive interviewing works best when all the participants are trained as researchers, this style of interviewing may work with participants who are not researchers, if the participants are given a role in the content and interpretation of the meanings in the interviews (Ellis & Berger, 2002, p. 857).

My participants had a say in the direction and content of both the interviews and focus groups meetings. For the most part, they controlled the direction of the conversation, the flow of conversations, and the topics that were discussed. As much as possible, I tried not to lead the conversation, but to join them as a researcher-participant by sharing my experiences of menopause and my observations on whatever topic we were discussing at the moment. But, as I mentioned earlier, as the researcher, I realize that I did have an impact on the interview and focus group processes.

In addition to having a say in the direction of the conversation during the interviews and focus groups, the participants also had the opportunity to read a copy of the final vignettes I wrote about them and to comment on them. I mailed each woman a copy of her vignette, and followed-up with a phone call asking if she agreed with my portrayal of her. Not every participant returned my call. But those I talked with agreed with my portrayal of them. As I did not hear from the others, I assume that they also felt comfortable with my portrayal of them.

### *In-Depth Interviews*

In-depth interviewing was a second qualitative interviewing process that I used in conjunction with interactive and collaborative interviewing. In-depth interviewing allowed me to disclose my personal views and feelings to the participants. In-depth

interviewing can be used successfully when the researcher is also a member of that class of research participants that are being studied. In-depth interviewing seeks deep information and understanding and is usually used when the information that is sought is not readily articulated or is taken for granted (Johnson, 2002, p. 105). I had hoped that in-depth interviewing would help me understand how the women had resolved certain issues, such as the invisibility of older woman in our society. I had also hoped that their stories might help me recognize their taken-for-granted underlying assumptions and sensemaking processes, helping me to recognize a participant's underlying value system and common assumptions about the world by her way of talking about herself and her life in menopause (Johnson, 2002, p. 106). In-depth interviewing was incorporated within each meeting with my participants, allowing the women to become more comfortable with me as the data gathering progressed, with them most comfortable during our final interview. As a result, I noticed that many of the women disclosed more intimate details of their lives during our final interview.

### *Autoethnography*

Autoethnography provided a way for me to insert my own voice and life experiences, as a woman in menopause, into my research study. I did this in several ways: by writing reflexive stories about myself and my personal experiences, through reflexive analysis of my interactions with the respondents, and through the reflections I had while I wrote the other women's stories. Reflexive autoethnography, also known as personal narrative, informed my research study. Autoethnography is an "autobiographical genre of writing and research" that is highly personalized (Ellis & Bochner, 2000, p. 730). Through autoethnography, "authors tell stories about their own lived experiences,

relating the personal to the cultural” (Richardson, 2000, p. 931). Usually written in the first person, the researcher moves back and forth between the cultural and personal aspects of her experience (Ellis & Bochner, 2000, p. 739). The goal, which focuses on the researcher’s life, is to understand some aspect of the researcher’s lived cultural experience.

I wrote evocative, emotionally rooted, autoethnographic, and impressionistic tales in the form of vignettes of my personal experiences coping with and making sense of menopause. Autoethnography also has allowed me to capture the rich, emotional aspects of my experiences and reflections while interviewing the respondents and while participating in the focus group sessions. Impressionist tales “reconstruct in dramatic form those periods the author regards as especially notable and hence reportable” (Van Maanen, 1988, p. 102). Impressionistic tales are evocative narratives complete with plot, character development, and suspense and can usually stand alone without extensive commentary (Van Maanen, 1988, p. 103).

I used sociological introspection to help me examine how my social and personal experiences “fused into felt emotions” (Ellis, 1991, p.23). Sociological introspection helped me delve into my own sensemaking, allowing me to root out my underlying values and frames in order to write richer, more evocative, and emotionally felt stories about my personal experiences and those of my participants.

#### *Constructing Personal Narratives and Category Analysis*

I wrote stories about the women’s experiences in menopause in addition to writing my own stories. I developed these stories from the focus group and one-on-one conversations. When deciding what to include in each of the women’s stories, I read the



transcripts repeatedly to identify topics that were important to the woman, so I looked for topics that the women discussed repeatedly during the interviews and focus groups sessions. Although I did not code my data in the traditional sense, I identified the topics that emerged in the women's stories. I then used those categories in my analysis of the women's sensemaking.

#### Issues and Concerns with My Methodological Strategies

It can be problematic for me as the researcher to write myself into the research project as I did. By doing so, I may have inadvertently silenced the voice of the other. In addition, my interviews may have served to create and sustain power relations in society and may have served to exclude the diverse voices that I tried to include through the interview processes (Briggs, 2002). So, even though I incorporated reflexive interviewing strategies into my research conversations while I was interviewing the women and while I was interacting with the women in the focus groups, in order to make my research collaborative and inclusive of the other, I recognize that I need to reflect upon some of the issues that called me to this project. "When telling the story of the research, the interviewees might reflect deeply on the personal experiences that brought them to the topic, what they learned about and from themselves and their emotional responses in the course of the interview, and/or how they used knowledge of the self or the topic at hand to understand what the interviewee was saying" (Ellis & Berger, 2002, p. 854). In reflecting upon the reason for conducting this research study, I realized that this project was really about me. It was about my frame, my sensemaking, my way of seeing and being in the world, and my body. As a result of this issue, I kept field notes,

and notes on notes about my personal reflections during this project so that I could reflect upon some key issues, such as:

1. To what extent has my analysis offered an alternative to the dominant discourse?
2. Have I worked to explain the position from which the participants spoke?
3. Have the participants reviewed the material and had the opportunity to dissent or challenge my interpretation of their story? If so, how do I report these departures?

A more complete list of key reflexive questions is included in Appendix G.

### Reflections on My Methodology

It sounds so neat and clean to say that I wanted to provide a venue for women who may have been marginalized to have a space to express their personal standpoints through my project. But as I analyze my data I must stay alert to whose voice I am hearing. Understanding ownership of the voice is complex and messy. For example, will I hear the voice of the medical community? Will I hear the voice of a single mom trying to cope with financial burdens in addition to coping with menopause? Will I hear the voice of a married woman reflecting patriarchal values? The respondent's voice might shift from one standpoint of experience to another over the course of the interview cycle (Warren, 2002, p. 84). Whose voice is it anyway? And how will I know which voice I am hearing? By choosing to talk with women who have bought into the idea of using HRT, have I already skewed the potential for this project to include the voice of women on the margins, as women of higher income levels may be more likely to take HRT than women of lower income (Finley, Gregg, Solomon, & Gay 2001)? Will the stories I hear

belong to the women, or will they be no more than a relanguaging of the discursive formations in our society that serve to constrain and frame our everyday experiences and understandings? Who owns the opinions and stories that will be expressed in the interviews that I plan to conduct (Gubrium & Holstein, 2002, p. 22), and “can we ever discern ownership in individual terms”(p. 24)? And how dialogic can I really be as a researcher, when I’m trying to root out another’s story? I need to be sensitive to these issues while I reflect upon and process the women’s stories that I’ll hear in my project.

### One Final Thought

During my research study, I carried with me a prepared list of psychiatrists available for the participants, but no one asked for this information, or appeared to me to be in need of it. One of my participants did phone me asking for the name of a physician who practiced natural methods of HRT that another participant had mentioned during one of our focus group sessions. I gave her the name of the physician that the participant had mentioned. This woman phoned me again more recently asking for the same information. This time I dug into the pile of information I had gathered when I had attended the seminars in the Tampa Bay area of HRT and the WHI. I was able to give her additional contact names of physicians who practiced natural methods of HRT.

In the next chapter I share the stories I heard from the women. In chapter four I analyze the women’s sensemaking and in the final chapter, I reflect on my findings and discuss areas for future research.

## CHAPTER 3

### STORIES ON MENOPAUSE

“Stories are the narrative frames within which we make our experiences meaningful” (Bochner, 2002, p. 73). When we tell stories about our lives, we engage in retrospective sensemaking, interpreting and reinterpreting past events. In the process of doing this, the meanings we derive from, and the sense that we make of, our stories, changes over time. This helps us bridge our present selves to our past. Threads of our stories form a special bond between the storyteller and the listener, in that the process requires collaborative sensemaking between all parties. The goal of any story is to help the teller come to terms with an event: “Why did this happen? How can I understand what it means? What lesson have I learned?” (Bochner, 2002, p. 81). So stories help us manage uncertainty and adversity in our lives. They provide us with a means to cope with the mundane but also the challenging. And dialogue helps to set the ground for the process of storytelling. In order to be in dialogue, one must be an active, in-the-present-moment participant in the interaction (Buber, 1999). Being in-the-moment allows the stage to be set for co-creating joint meanings with the other. The stories that follow explore my participants’ sensemaking on menopause. All of the stories were constructed from the transcripts of my one-on-one interviews and focus group sessions with the women, except for the final story written about Malika. That story was constructed exclusively from the transcripts of the Tuesday focus group sessions. I included one

focus group story for several reasons: (a) Because Malika's one-on-one interviews did not address the topic of menopause as directly as the other women's interviews did, I used a focus group to produce her story, and (b) I planned to incorporate at least one focus group story in my study in order to add an additional depth and breadth to my research project, so it seemed appropriate to incorporate Malika's story in this way.

### Stephanie's Story

I am driving south on I-75 this bright Wednesday morning, to meet with Stephanie, one of my research participants, for our first one-on-one interview. Cold air is blasting from the air conditioner of my Ford Escort, and my hands are gripping the steering wheel in the traditional 10 and 2 o'clock positions, as I speed down the expressway. The radio is tuned into a PBS documentary about people who like tattoos, but I barely hear the commentary. My attention is focused on my preparation for my meeting with Stephanie.

*Let's see, I brought two tape recorders with me. I tested the larger one at the seminars on menopause that I attended last summer. So, I know it does a great job recording. But the smaller one, my backup, has not been tested.*

*I hope I brought enough tapes for both units.*

*I hope I brought enough batteries for both units.*

*Where did I put those batteries?* I snake my right hand into the opening of the black briefcase lying on the passenger seat next to me and rummage around, until I feel the hard roundness of the large batteries. I continue rummaging through the briefcase until my hand comes in contact with the smaller, AA-sized batteries.

I sigh.

*What if she and I don't "click?"*

*Then what should I do?*

*I don't want to appear rude or awkward.*

*Well, I'll just have to wing it and hope things work out.*

*Stop worrying!*

*You are an excellent interviewer.*

*You have interviewed people a thousand times before, so just try to relax and be yourself.*

*Yes, I affirm, as a way to soothe myself.*

*You are an experienced interviewer.*

*And people feel comfortable around you.*

I reflect on the career I had in business before entering my Ph.D. program. I have always worked with people, facilitating meetings or interviewing employees while in management, professional sales, or organizational development.

*Yep, I should be okay, I conclude.*

*And Stephanie appeared to be very verbal, open, and friendly when we talked over the telephone last week, I reason.*

*I should be okay.*

*Well, I hope she feels comfortable talking about herself with me this morning.*

An SUV cuts in front of me. I slam on the brakes and slow down to create more distance between us.

*Crazy driver! Drivers are so reckless in Florida. I shake my head.*

Stephanie and I had talked over the phone a few weeks ago to arrange this meeting. At that time, she gave me detailed directions to her place of business and told me to expect the drive to take around 45 minutes. I left an hour early to be sure I was on time for our 9:00 appointment, because I thought the morning traffic would be heavier than it is today. Stephanie, a 50-something year old Caucasian woman, works at a medical facility in west central Florida. I am happy that she is the first of the group of women whom I will be interviewing for my research project. I think we have a lot in common.

*We are both childless.*

*We are in our 50s, but she is a few years younger than I am.*

*We are both single, but she has a live-in partner. I have none.*

*We both have advanced degrees.*

*We are both in professional careers.*

*Well, I rationalize, I am a doctoral candidate at the moment, but will soon be working as an assistant professor, once I finish my dissertation and get a real job. But I'm close enough to a professional status, I reason.*

*And we are both through menopause.*

I pull off the expressway at the next exit. The sight of beautiful, stately palm trees lining both sides of the road catches my attention, even though I have lived in Tampa for 5 years. I'm originally from Illinois, so I'm not accustomed to such a beautiful sight on a daily basis. Living in Tampa has been like living in paradise, except for the fact that I have never had the time or money to enjoy my surroundings since I've been here. My Ph.D. program has required all of my energy.

I pull into the parking garage, park my car, and follow the exit signs to the lobby elevator. Stephanie's directions call for me to take the elevator to the top floor and walk to an adjoining hallway that will lead me to her office. I hop into the elevator, press the number, and wait. My heart beats faster. My hands begin to sweat. A broad grin forms on my face. I am elated to be here today, starting my data collection process.

When the elevator doors swing open, I step into a dimly lit hallway. The smell of antiseptic assaults my nostrils.

*Pine Sol!*

I am surprised to make this connection.

*The squeal of a skid, straining under its load,* pulls into my mind.

*No, this can't be,* I reason.

I look to my right and see the sign, "Dialysis."

Sometimes our memories lie dormant just below the surface of our consciousness, tucked away in a private place in our mind, ready to leap into the present without warning. Like water spilling from a cracked glass, seeping slowly through the seam at first, until it bursts through the jagged hole, in an ever-widening circle.

Certain memories retain their power, long after the sharp edges of the actual incident have faded, like a wound that won't heal properly. Walking through the dialysis ward on my way to Stephanie's office caught me off guard this day, flooding my consciousness with a cacophony of memories from my past.

The screech of iron wheels straining against the cement floor. Darkly colored, wooden skids piled 6 high by 6 deep, loaded with boxes of fresh, eviscerated chickens being pulled into the doorway. The antiseptic smell of Pine Sol mixed with the sour



scent of chicken water wafting through the air. Willie B, tall, dark, and handsome, dressed in the market's traditional blue and white striped smock, standing over a skid of chickens with a half-smoked cigar hanging out of his lower lip, screaming out the weights of the boxes in his deep, guttural voice: "65," "73," "61," "69," "62," while telephones ring in the background, demanding attention.

An image with my father pulls into my mind.

*"Linda, L-i-n-d-a!" He yells up the stairs of our home.*

*"It's time to get up. It's 5:00 a.m., time to get up. You're going to be late for work if you don't leave soon."*

He rests a spindly leg against the banister, hanging onto the railing for support with an equally thin arm. A black patch covers his clouded right eye, the result of a stray blood clot. My sweet father, diagnosed with kidney failure at the young age of 46, is too weak to work any longer. His body is filled with a mixture of Demerol to ease his pain and waste materials that need to be flushed out of his blood, because his kidneys have stopped functioning.

Dialysis centers were not common in 1967, when my father was diagnosed with kidney failure, and little government support was available. Six months after he was diagnosed, his medical insurance coverage was exhausted because the medical bills were so high. My mom shuttled my dad back and forth to a hospital in Iowa City for over a year, so he could be dialyzed three times a week. Sometimes they spent months and months in Iowa City, when my father's condition was so critical that the doctors thought we could lose him at any moment. But eventually, when he was strong enough to come home, we purchased a new washing-machine-sized kidney machine, arranged the den

like a hospital room, and my mother learned how to dialyze my dad at home. She would dialyze my father three times a week for about 4 hours each time.

During the three-year period my father was ill, I stepped into his role as the owner and manager of a small wholesale poultry business at the Fulton Market in Chicago, Illinois. Six days a week, week after week, I trekked into the city, leaving home before dawn and arriving back home long after nightfall, sometimes as late as 10:00 p.m. in order to manage an unfamiliar business in a dangerous part of town so that we could ensure that my father's medical bills and our house bills were paid. I purchased two semi-trailer loads of fresh eviscerated chickens from a supplier in the south. The chickens were trucked to me in an air-conditioned trailer, smothered in layers of ice and packed in sturdy boxes for the long trip to the Fulton Market. I sold the boxes of chickens to restaurants and grocery stores in the Chicago metropolitan area and handled the normal day-to-day troubles associated with a small business as best I could. The staff consisted of three or four drivers who delivered the chickens, two housemen who cut the chickens for special orders, and Willie B, who helped with anything that needed to be done, such as dispatching the drivers, arranging their routes, and loading the delivery trucks. He also watched over my safety. Six days a week I sold boxes of chickens, took in the cash from the drivers, generally watched over the business, and handled any problems. On Sundays I worked on the books, paying bills, posting to the accounts receivables, and preparing statements. I was nineteen.

*Should I tell Stephanie part of my story? I wonder. Should I tell her about the memories that have been swirling through my mind since I stepped off the elevator and found myself on the dialysis floor of this building?*

I stop in front of a small, but brightly lit office. Stephanie, wearing a traditional  $\frac{3}{4}$  length white smock covering her street clothes, invites me in. After our greetings, she offers me a seat across from her at a round table that takes up half the space of her office. On the far side of the table is a file cabinet next to a small refrigerator. Perched above the file cabinet is her Master's diploma. A computer, printer, and small tabletop desk stacked with neat piles of file folders line the entire wall on my right.

"This is a dialysis area, isn't it?" I ask, still mulling over how much to tell her about my flashbacks and when to do so.

This interview between Stephanie and me is a social production, a collaborative construction between the two of us—"a site for knowledge production rather than simply a neutral conduit for experiential knowledge, as traditionally believed" (Fontana, 2002, p. 166). Interviews are situationally and contextually produced. During my interviews, I want to bridge the traditional relational gap that exists between the respondent and interviewer, with the hope that together we can become more equal partners in a negotiated dialogue. Even though traditional interview protocols would encourage me to maintain a distance from the participant, and to hold off from revealing my experiences about my life to the participant, I want to close the hierarchical distance between us (Reinharz & Chase, 2002, p. 228). I think about my hopes for our interview, while I mull over what to reveal to her.

But there are other issues I need to consider as well. Would my impending self-disclosure serve to tighten our bond, putting Stephanie at ease and on a more equal footing with me, or will it serve to pressure her to reveal things she might not want to reveal? Will revealing my memories serve to share power with Stephanie, or will it

simply allow me to drone on and on about myself rather than listening carefully to Stephanie's story (Reinharz & Chase, 2002, p. 228)?

*I need to be cautious, especially as this is my first meeting with her. But our relationship is reciprocal, I reason, so shouldn't I share my in-the-moment thoughts?*

"Yes, that area is dialysis," she responds, interrupting my ruminating.

"My dad was a dialysis patient a long time ago, in the late 1960s," I blurt out.

"Wow, before transplants."

"Well, that's right, for the most part. He passed away in 1970. My mom learned how to dialyze him at home, dialysis centers were just forming at this time, and we bought a kidney machine and dialyzed him at home. Can you believe that?"

"Was it peritoneal?" she asks.

"Not exactly. He didn't know what was wrong with him at first. He wasn't feeling well and although he had been thin all of his life, he had noticed that he had begun to put on a little weight. I was home from college that summer, my first year, and my dad had just opened a wholesale poultry business a couple of months earlier. On the day he finally decided to see a doctor to inquire about his symptoms, he asked me to go down to his business to take in the cash. I had never worked before this, except for babysitting a few times. I didn't know anything about business. My dad dragged himself, actually drove himself, first to see his physician and then to the hospital, and he never came out of the hospital. His blood count was so low that the doctors didn't know how he made it to the hospital without getting in an accident. They thought he should have passed out. So they ran tests and found that he was in kidney failure. They did use peritoneal on him at first, but he wouldn't have survived for very long on that."

“Because some people—I imagine they’ve probably improved the technology over the years,” she suggests.

“I know at that time, as I understood things, you couldn’t live very long on peritoneal,” I explain.

“Where did you grow up?” she asks.

I tell her more about my background, and we continue our conversation on kidney disease. I describe how the dialysis process worked when my mom dialyzed my dad at home and talk more about my memories of managing my father’s business.

“So, anyway,” I sigh, “that is what happened to me when I walked onto the floor of the dialysis unit today.”

“It brought back a lot of memories for you,” she confirms.

“Yes, even though I didn’t spend time at the hospital when my dad was sick.”

“It certainly changed your life,” she declares.

*I am surprised at her level of reflexivity on this topic. And she certainly seems interested in knowing about me.*

“Yep,” I state, matter-of-factly. “I was nineteen, a baby. And I didn’t know anything. I was clueless about my dad’s illness and how to manage a business. But I did it for three years, and then my dad passed away.”

“Were you the only child?” she inquires.

I tell her about my older sister and younger brother.

“Were your parents immigrants?” she asks.

“No, but I found out much later that this is something that first-generation immigrants do [own wholesale businesses]. My father was born in Greece, but brought

to America when he was eight-months old. He had been in the grocery business most of his adult life, owning a grocery store before he started the wholesale poultry business,” I explain.

“It sounds like he was an immigrant, or a first-generation or somebody who came over [from Europe], because your family bonds were so tight. It sounds like you really did something to help your family out, and you felt like that’s what you had to do,” she comments.

“I didn’t see an option,” I explain. “I couldn’t imagine doing anything else at the time. Even now, years later, when I think about that very painful and difficult time of my life, I am so happy that I did not walk away from my family,” I confide. “I would not have had it any other way, even though roles reversed and I lost all of my friends during that time. I had to grow up too quickly.”

“Yeah, yeah, it sounds like you have a strong family, which, I don’t know [her voice trails off.] You know, it’s funny, because I never thought of my family as being particularly strong, so when I come across people who are so tight, so close, as I do in my work here, I recognize that it’s different for my own family. My family was pretty laid back about things, and they didn’t bring the children into a lot. Like if there were troubles, we were protected from it,” she explains.

“Me, too. Growing up I led a pretty sheltered life. In fact when my dad first became sick, my mom didn’t tell us about it, so I really didn’t know for a while how severely sick he was. She just told us that he was going to be in the hospital for a few days. And I don’t recall anyone asking me to stay at my dad’s business. My dad asked me to go in one day to take in the cash, and that’s what I did, day after day, I just took in

the cash. Things evolved from that, and I never stopped going. My mom was in a crisis situation, but I didn't realize it at first."

"My boyfriend's parents are German. For the longest time I thought he was an immigrant, until I discovered that he was born in New York. But they spoke German at home, and his parents had been immigrants, and it sounds like they had that kind of family, where you would automatically help out, no questions asked," she explains.

We talk more about my background, before reviewing the IRB consent form. After we finish with it, I explain that I came here today to chat with her a little bit and that we could talk about whatever she wanted to talk about.

"Doesn't necessarily have to do with menopause, right?" she asks.

"No, because your whole life experience affects what you are today and how you make sense of your life in menopause." I explain.

"Well, I grew up in Tampa, actually born in Orlando, but within a month of my birth my parents moved to Tampa. They went to the university there, and we lived in the married dormitories until I was around 3-years old. Around that time we moved into my grandmother's home where my father had grown up. So, we lived there for a while. I went to grammar school, the same one my father went to, and then we moved to south Tampa and I went to private school from then on.

"Sounds nice!" I exclaim, marveling at how different my own parent's background had been. Her parents were college-educated mine were not.

"Mmm, it was convenient," she confirms. "I have an older brother and younger sister and they too went to private school for a while, until they got into high school and then they transferred to the public schools because they didn't like private school. I went

to a public college, and got a degree in economics. I have never been married. But I've always lived with guys and in the interim have had various boyfriends."

"You've never been married?" I inquire. "That's interesting."

"No, and no children," she confirms.

"I've never been married, either," I acknowledge. "I think we're relics."

"There you go," she agrees. "What would you call it—a response or result of the women's movement?"

"Do you think so?" I ask.

"Oh, yeah. I always felt that I would have to be able to afford a nanny and that my kids would have to go to private school. And if I couldn't do that then I just didn't want to have children," she confides.

"Did you feel like you couldn't afford to have children?" I ask, thinking about my own situation.

"Oh, yeah. Absolutely."

"Isn't that interesting!" I exclaim. I have always felt that I couldn't afford to bring a child into the world because I was too poor. And then you look around and see other people having children and living paycheck to paycheck, and they seem to have managed. So, did you ever wonder about that contradiction? That you thought—that's interesting that you thought the same thing I did—I thought how could I bring a child into this world when I'm not financially set?"

"That's right! That's exactly how I felt," she exclaims.

"And I might not have a husband, and I wanted to do it [have children]."

"The RIGHT WAY," she interjects.



“And what is that right way?” I ask.

“Well, for me it would definitely be having a partner to share the responsibilities, and I’ve never thought of any other kind of relationship besides being in a married relationship. I don’t necessarily have to be married to have children, but I never thought I would be in an unmarried relationship with children. That’s not me,” she explains.

I tell her my story about Buzz, a close friend from high school who agreed to be my sperm donor when I was ready to have children if I was not married at that time.

“Oh, I had plenty of sperm donors,” she confides. “I wasn’t concerned about that. I was concerned about having that perfect situation, which of course never really arises. I figured that if I had things financially or materially, I could provide the rest. I’ve had three or four abortions, so it’s not like I couldn’t have kids, or I didn’t have somebody. I just did not feel that it was right for me to have children at that time, because the relationship was probably in turmoil. I knew it wasn’t going to last, or something like that.”

“Sounds like your focus was really having the perfect nuclear family—a family unit with a partner, a male partner, before you had a child,” I conclude.

“Right, yes,” she confirms.

Our conversation turns to menopause.

“I had some mild heat flashing,” Stephanie explains. But that isn’t why I decided to go onto HRT. I developed a deep burning that felt like I had a thousand bugs burrowing into my vulva. It wasn’t vaginal or inside. It was like when you get sweaty. I would be at work and would have to run to the bathroom. Standing in the small stall, I

would rub and scratch the area until it was ragged and raw. I thought I would lose my mind. I could hardly make it through the day.”

“Ugh! That sounds awful,” I exclaim.

Stephanie grins, and small wrinkles form in the corners of her twinkling blue eyes. Scooting her chair closer to the table, she leans forward and clasps her hands together. Lowering her voice to a confidential level, she continues her story. “I was in graduate school. I mentioned it to someone. I said, ‘God, this is insane. I have this itching.’ And they said, ‘yeah, me too.’ And they were about my age. We were all in our mid-forties and we were all laughing, saying we had had this experience. But nobody else seemed to really find it life changing but just an annoyance. So I went on like that for a few years, and it kept getting worse and worse. I went from top gynecologist to top gynecologist, but the doctors didn’t want to give me anything because I still had my period. No one seemed to recognize this problem as being related to menopause. I went to a dermatologist who suggested I shave it to see if that helped.”

I let out a small gasp, thinking how uncomfortable that would be.

“And I guess I was too stupid to think about going on birth control pills, especially because I knew that birth control pills would prevent me from losing weight. I felt like I had gotten fat on them in the past, so I wouldn’t take the birth control pills. I didn’t recognize the possibility that they might have helped my vulva itching. But nobody really sits down and has a great discussion with you about this stuff. You’re on your own.” She opens her hands wide for emphasis. Her shoulder-length thick, blond hair bounces in unison with her animated body movements. “Finally, I went to a nurse

practitioner and she was appalled and said I would have to see the doctor. And I knew it was cancer!”

I moan, “Oh, God. How frightening that must have been.”

“Because just out of college, when I was 21, I got a job at a hospital. I used to pull specimens out of the refrigerator. This was around 30 years ago. I pulled this bag out of the refrigerator and it was a shaved vulva!

“Yikes,” I exclaim.

“I’ll never forget that. I’ll never forget the male doctors cutting up this specimen trying to make light of it. The doctors couldn’t help but mention that this woman had six kids and wasn’t ready to die—she was young. And you know that picture stayed with me all of my life. Thinking that this could actually happen to someone—they could have their vulva removed.” She halts. “I don’t know.” [her voice trails off for a moment].

“So the doctor goes, “Oh, I think we need a biopsy,” Stephanie continues. “And I’m like, here we go! And of course it’s very uncomfortable. You can imagine. They take a little chunk of skin. And they give you something numbing, but still, it’s like ‘oh, my gosh!’ But it came back as just dry skin. It was called vulvar dystonia or something like that. I’m 50 now, and have been having hot flashes for a few years. My periods stopped about two years ago. Right now I’m taking Ortho-Prefest, which is like a low dose hormone. My gynecologist recommended I take it because of my vulva itching. But going through menopause with these symptoms was a big surprise to me. Honestly! My mother said that she never went through it, she just stopped having her periods and she just never noticed it.”

Stephanie's head bobs from side-to-side as she talks. Strands of blond hair slip forward, hiding her face for a moment.

“So I never had a mother who set an example,” she continues. “I don't think that I ever really thought a whole lot about it, you know, going through menopause. I never thought that I would have problems.”

She pushes a wayward hair behind her ear while letting out a long sigh, and leans back in her chair. She stares off into space, reflectively for a moment.

*I am surprised to hear that she didn't realize she was going through menopause, especially as she is educated. She has master's degree. I imagine that educated people, especially people working in the health care field, would know just what to do. They would “know the facts,” but things don't work that way with some medical conditions, and menopause is one of those.*

“How long do you plan to take HRT?” I ask, wondering if the recent findings of the Women's Health Initiative have scared her.

“I went off the Ortho-Prefest for a while, because of the scare about hormones causing breast cancer, but then my symptoms returned. So I went back on them at the same dosage. I envision taking HRT as long as they keep my symptoms at bay, and I don't know how long that is going to be.”

“What have you learned about menopause and HRT lately?” I ask.

“I have learned that hormones keep you kind of fat, and I have totally lost my, eh, not ambition, but my desire to exercise. I got into this thing with a personal trainer, but then all of a sudden I did not want to do it anymore. It kind of coincided with menopause. I don't know why, but I have learned that HRT could be dangerous, if you

have a propensity towards breast cancer, but that hasn't stopped me. My vulva itching was way too intense to stay off HRT! It's made a big difference taking HRT. I plan to stay on it as long as I can."

She adjusts her glasses, scoots to the edge of her chair and crosses her legs. Looking straight into my eyes with a wide grin on her face, the room goes silent for a moment.

\* \* \* \* \*

Stephanie and I hold our second and final interview at my apartment in New Tampa. Her interview is my last for my research project. We tried to get together several times, but each week our appointment was moved. She has just recovered from a nasty cold, and had been taking antibiotics for it. She came over for brunch on a Saturday morning in mid-November. I served a three-cheese quiche, fresh strawberries, sliced cantaloupe, steamed asparagus, sliced tomatoes, orange slices, whole wheat bread with hummus, orange juice, and freshly ground coffee, brewed the way Stephanie likes it, very, very strong and served with loads of cream.

"Is this your mother?" she asks admiring the family pictures that are sitting on the mantle in the living room. "Oh, she looks so young!"

"Yeah," I respond. "That's my mom. She is sitting next to my uncle Fiore, her brother. These are my Italian relatives. This picture was taken at my nephew's wedding." I point to the man standing next to my mom. "That's my brother Jimmy, my sister Georgia, and there is my niece Stephanie with her fiancé Jon. There is my nephew Jim with his wife, Tammy. Oh, and there is my cousin Mike. He helped me drive my car to Florida from Illinois this summer."

I point to a picture of me dressed in a black and white costume, black top hat, white gloves, and holding a long cigarette holder. There is a white carnation on my lapel. I look like an old-fashioned hatcheck girl. “I was a penguin for Halloween one year,” I explain. “You can’t see my feet, but I had huge orange feet and a big belly. A friend of mine made the hat, cigarette holder, and a wonderful black mask with a huge orange beak.”

We load our plates with food and settle in at a small table in the living room. I double-check the tape recorder to ensure that it is working properly.

“So, what are we going to talk about today?” she asks.

“I want to catch up, ask if you have changed anything since we talked last, go through your pictures, and I have a few questions to ask as a wrap up.” I explain.

“Because of the scare on the estrogen and everything, I switched. My doctor asked if I would like to switch over to something else because of all of the dangers that are associated with estrogen. He said that I could try progesterone, plain old progesterone for a while.”

“Was it a pill?” I ask.

“Yeah.”

“How did it feel?” I ask.

“Oh, I didn’t think that it did anything, so I went back to Prefest. I was on Ortho-Prefest when we spoke last, but the manufacturer changed and the pill is now just Prefest. I guess Ortho is finished with HRT now.”

“And that is an estrogen/progesterone combination, right?”

“Yes. I was getting some hot flashes. So I caught my doctor in the hallway [at her job] and I said, “I think I want to go back on the Prefest.” He said, “That’s fine. You have to do what makes you feel good.” He said, “If I were a woman and I had symptoms, I would probably take estrogen too.” I mean, I guess he couldn’t come right out and say that it’s fine to take estrogen, but he said he would probably be doing that [taking HRT].”

“Did you have any particular symptoms that caused you to return to HRT?” I ask.

“Yeah, um, I had hot flashes again, and my vulva itching came back. It was not pleasant.”

She complains that the small chairs we’re sitting in are not comfortable, so she moves to the chaise lounge, the only real piece of furniture I have in my living room. I sit next to her in a collapsible, patio chair.

“So,” she continues. “The only disappointment I have is the fact that I feel like I am overweight. Of course, I am overweight according to the standard, but I don’t notice it too much, except when I try to do certain positions in yoga, like putting my head to my knees. My partner wants me to lose weight. I want to lose weight, but I don’t want to put any effort into it. That’s the bottom line. I don’t want the hassle. My partner has gone back to working out with weights. So he will probably lose plenty of weight and look great.”

“Men lose weight quickly,” I suggest.

“Isn’t that just the rudest thing?” she complains.

“I think it’s because they don’t have much estrogen in their bodies. I read somewhere that it’s difficult to lose weight once a woman hits menopause. It takes a

great effort. Did your vulva itching go away when you went back to taking your Prefest?" I ask.

"Yeah."

"How long do you think you will stay on the Prefest?" I ask.

"I don't know. I also don't want to get wrinkly looking, so I'm going to get some StriVectin. It's the newest thing out for your complexion and getting rid of wrinkles. Have you heard of it?" she asks.

"No, but you don't have any wrinkles, Stephanie. You have beautiful skin."

We look at the pictures she took of herself in menopause and one of them is a picture of several bottles of pills. There is her HRT bottle, and next to it is a bottle of Lipitor.

"I take Lipitor for cholesterol, because once you hit menopause your cholesterol goes up. Mine was almost 300, but it used to be 180," she says.

"I wonder if it does have something to do with our loss of estrogen," I ask.

"I think it is related to menopause, because it happens to most women, their cholesterol goes up," she concludes. "A friend of mine is a transplant cardiologist, a real believer in medicine and she told me I had to go on the Lipitor. Doctors can't deal with anything else [besides pills]. She kept telling me that I needed to go on it. I didn't want to because you hear about all of these side effects, but my primary care physician also said I should go on it. He told me his 85-year old father was on it, so I finally went on it and my cholesterol dropped to 200."

"So, why did you take this picture of your medicine?" I ask.



“It’s just an indication that I’m getting older. I went from never taking anything to talking a lot of stuff.”

“You are healthy, though.”

“Yes, and I could probably do without them, except for my Lipitor. I think if I exercised I wouldn’t need Lipitor. I think I need that because of a lack of exercise and because of the hormonal changes.”

We look at the remainder of her pictures. Most of them are pictures of people that she works with.

“During the focus groups you had a chance to talk about menopause with other members and I wondered how you felt being a part of the focus groups. How did you feel about them?”

“I felt like we had very similar experiences. I’m very open, so I don’t have a problem with that kind of stuff, but I thought the Muslim lady was a little off-beat. But it takes all kinds of people for the world to go around. I liked talking with the ladies. And Ruby, the older woman was in such good shape.”

“What did you think about having me as a participant in the focus groups.”

“Well, it felt like you had issues you wanted to work on. Like you were being affected by all of this too, just like we were and you had questions, and it was kind of like, God—there are other people going through this too?”

“So having me as a group member, participating, was all right with you?”

“Oh, God, yes.”

### Bunnie's Story

I am speeding south on I-75 today, on my way to meet Bunnie, the youngest of my participants, for her first interview. She has graciously invited me to lunch at her home. She gave me excellent directions to her home and traffic is light this morning, so I arrive a few minutes early and locate her home easily. But I roll slowly past it, in order to admire the neatly manicured lawns, stately palm trees, and beautiful homes in her neighborhood. I have lived in Florida for 5 years now, but I still enjoy looking at Floridian-style architecture and landscaping, rather than the Illinois styles I am familiar with. I am particularly fond of miniature palm trees that remind me of oversized pineapple tops. I think they are cute. The street is silent, except for a few short bursts of laughter coming from two blond-haired children engaged in a game of tag on the lawn of a lushly landscaped front yard. This silence is a far cry from the bustle of people and heavy traffic of my Temple Terrace neighborhood.

At 10:30 on the dot I pull into her empty driveway, and jump out of my car with smile on my face and my book bag slung over my right arm. I walk briskly to her front door, past a mound of dirt on the front lawn and press my finger firmly on the doorbell. At that moment, I realize that, as a good ethnographer, I ought to be recording the very start of our conversation. I plunge my hand into the book bag, frantically feeling my way past cellophane-covered tapes and a spiral notebook, searching for the tape recorder I purchased specifically for my interviews. I am relieved when she does not answer, so I

run back to the car to set up the tape recorder just as a Maroon SUV whips past my car and screeches to a stop near the side garage doors. A petite and trim young woman, with shiny, auburn chin-length hair bounds out of the car smiling and waves energetically to me. She is dressed in a white outfit traditionally worn by people who are involved in the martial arts. She is the picture of health, with alert brown eyes, and a dewy complexion that is the hallmark of a young person.

“Hello, Linda,” she says, pronouncing the “i” in my name like a hard “e.” “I hope you have not been waiting too long. I am so sorry to be late. My Tai-Kwon-Do lesson went a little longer than usual,” she explains, smiling at me, her accent slowing down my comprehension of her words. “Please come in, and welcome to my home.” Bunnie steps aside to let me inside the front door.

The interior of her house is arranged in a traditional two-story colonial style similar to the homes I’m familiar with in my hometown in Illinois, with a living room to the right of the foyer, and the dining room to the left and stairs off the foyer leading to the second floor. She leads me through the dining room to the kitchen. The kitchen has a row of windows stretching across one side of the room, letting in bright, Floridian sunlight. Beyond the kitchen window is undeveloped land as far as my eye can see. While she explains to me that the house sits on two acres of land, I notice that the backdoor is ajar. I can feel a cool breeze moving through the kitchen, but I don’t complain. I know that the breeze will come in handy in the near future, when surges of heat begin to course through my body.

“It’s so sweet of you to invite me to your home, Bunnie,” I state. “It’s beautiful and your yard is so large.

“The house is 22-years old. We moved in around 2 years ago. We had to remodel the kitchen, bathroom, and the pool area, but we’re still working on the landscaping,” she explains in her thick accent. “But first we had to get our beeseness going.”

“*Bees-nest?*” I ponder her meaning. “Excuse me, Bunnie? What did you say?”

“Oh, my goodness,” she exclaims. “My accent gets in my way.” She laughs.

“My husband and I have a bees-i-ness.” She enunciates each syllable slowly.

“Business! Oh, what business are you in?” I inquire.

“I’m an architect and my husband is a builder,” she explains. “We have a construction company. We’re in the process of building a neighborhood.”

“Wow!” I exclaim. “Isn’t that neat.”

“Yeah, all of the houses are traditional, American architecture. So they will have porches and columns, and shutters,” she explains. “Would you like Jasmine or Persian tea?” She hastily begins filling the large teapot with cold water from the kitchen tap.

“I don’t think I’ve had either type,” I confess.

“Then let’s try Persian.” She nods her head.

“Your backyard is beautiful,” I exclaim, still admiring the view out her kitchen window.

“It goes all the way back to a big pond. But we haven’t cleared all the way there yet. We tried to clear the area, but the brush grew back. I would like to have an orchard back there someday,” she confides. “With a little picket fence and an arbor with plants growing. And then I would like to place that little shed over there, and put it right in the

middle of the property with flowers all around it.” She points to an imaginary center of the outside yard. “And then have mango, orange, guava and all kinds of trees.”

“Oh, that would be lovely.”

“If I let them, the children will go all the way back, especially my younger one. He will just go and go,” she laughs. “The older one knows better than to take off, but the younger one is very curious, so I’m afraid that he might cut himself with a branch.”

“But it’s nice to have a place where the children can explore.”

A sweet scent wafts through the air.

“Mmmm,” I marvel, “what is that wonderful smell?”

“It’s Cardimon. It gives a really nice touch to the tea. Where would you like to sit, Linda? Would you feel more comfortable here or in the living room by the bay window?”

“Let’s sit here in the kitchen, by the door,” I state, thinking strategically again about the cool breeze. I begin pulling items out of my book bag: tape recorder, two copies of the informed consent forms, extra tapes, and note pad, arranging them neatly on the kitchen table. “Your home is so private, Bunnie. I love it!”

“Yeah, I like it here a lot. Sometimes I forget where I am and think I am on vacation. I’m cooking and cleaning and doing my own thing. I feel like I am someplace else, in a country house.”

“What is the name of the class that you are taking?” I ask.

“Tai-Kwon-Do. It’s a Korean martial art. It’s the best thing I have ever done. I have adapted very well to learning this sport. It challenges my body and mind, and it is translating into my daily life as well,” she explains.

“How is that?” I ask.

“I have a very tough schedule keeping up with two boys. They are very active. I pride myself in making sure that they eat fresh food everyday, cooked from scratch. They are very well kept, and I dedicate myself to them that the house is clean and organized, that there is order in their lives and fun, and that we are close. And I participate in their things. I started taking Tai-Kwon-Do because they started taking it.

“What a nice way to be involved in your children’s lives!” I exclaim.

“And they cannot tell me that they cannot do it, that’s it’s too difficult,” she chuckles softly.

“Because you can do it.” I finish her thought.

“Exactly! And I think that if I would not have started with the progesterone cream, I wouldn’t have the energy to do it all. I had a great lack of energy. I was really tired and I felt sad for no reason. And of course all the other symptoms that we know are related to the hormonal imbalance that comes with premenopause,” she explains.

“Like what?” I inquire.

“Because I’m in my thirties. I was always wondering when that would start [menopause] because I had my first period one month, exactly one month, before I turned 10 years old. That was many years ago. So I knew that sometime early in my life I would have the symptoms of menopause. But I never thought they would happen this early. I didn’t know there was such a thing as premenopause.” Her auburn hair bounces when she shakes her head in amazement.

*I too had my first period at the age of ten. I smile at this recollection. My mother gave me a pamphlet called, Now you are Ten. And when I finally did have my first*

*period, my mom celebrated with me by taking me out for an ice cream cone. I felt special, but at the same time confused, because I had blood pouring out of me, and my mom announced that now I was a woman! Wow, I was far from that! I was a baby, a tomboy, who was also a fast runner able to outrun most of the 8<sup>th</sup> grade boys on the playground, still sporting long, blond pigtails. And I didn't really realize that I was going through menopause when I turned 50. I went to the health center thinking I had symptoms of the flu. But now that I know some of the symptoms of perimenopause, I recognize that I had had sporadic symptoms of perimenopause in my late 30s and 40s. I am surprised to realize that Bunnie is so aware of her body. I, on the other hand, am dense. She definitely has a deeper level of awareness of her body than I did at her young age.*

“So it was interesting when I went to see the doctor,” she continues. “He looked at my body and said, ‘You’re keeping weight in the middle section of your body because your estrogen is too big.’ I was high on estrogen—dominant. I was estrogen dominant. Of course, I am Spanish and have wide hips, but it was more than that. So, that is how it started. We did the saliva test and it showed that I was really out-of-balance,” she smiles.

“You had more estrogen?” I ask.

“I had too much estrogen and very little progesterone. So I started using the progesterone cream. And it made a big difference. It took about a month for me to feel better,” she explains.

“Oh, there is someone in the garden,” I interrupt, startled to see a man walking through her backyard.

“Yeah, that’s our gardener. Don’t worry, Linda. Anyway, it took about a month, but I really started to see changes. The first one was that I didn’t feel so tired anymore and I didn’t feel so anxious. And I had also been having trouble with my bladder, so I went to the doctor to find a solution to that problem at the same time that I started on the progesterone cream. He suggested that I have surgery because the uterus is pressing against the bladder. But my situation isn’t so bad yet. I’m too young to have surgery and I don’t want to have my uterus removed just because of that,” she confides. “I went to a urologist to have further testing done, and we concluded that it wasn’t necessary for me to do that yet, because with Kegel exercises, I can keep the symptoms under control.”

“Oh, that’s good!” I exclaim.

“And then when I started with the cream, I noticed a big difference. I rarely have a problem now,” she smiles and lets out a sigh of relief.

“I think I met the doctor you are talking about at one of the seminars at the Marriott in Tampa.”

“Well, you heard in his seminar that this discovery of the progesterone cream actually turned his practice all the way around because he was not doing this kind of therapy before,” she explains.

“He was working in traditional medicine before. That’s what he told me.” I think back to the doctor’s presentation at the seminar I had attended.

“Now he is more understanding that there are other ways to actually improve health without being so radical with traditional medicine. He also has a great knowledge of vitamins and minerals. He has recommended the vitamins to take and all of that, but I have a hard time taking stuff because they make my stomach very sick. So through my



diet, I would rather come to a more healthy way of being, although I know that they can benefit me a lot, the fatty acids and a complete multi-vitamin for women, and also the calcium,” she explains.

“I too have a difficult time taking daily vitamins, but for a different reason.” I explain. “My thyroid closed down about a year or so ago, since I’ve been in my Ph.D. program, so now I have to take Synthroid daily. The endocrinologist I saw diagnosed me with nonspecific thyroiditis. I have to take the medicine early morning and wait for one hour before I can eat anything. But by the time the hour is up, I have to leave for school, so I’ll bring yogurt or something else that is portable to eat while I’m at school, and as a result, I usually forget to take a daily vitamin pill.” The room goes silent. I reflect for a moment on the struggles I have had with a weight problem since I’ve been in my doctoral program and since I was diagnosed with a thyroid problem.

“Linda, did you say you don’t even eat?” she asks, surprised at my announcement.

“No, I can’t eat until the hour is up.” I explain, sighing in resignation over my dilemma with eating and weight management.”

“Can you wake earlier and take it, then go back to sleep?” she offers.

“Well, I usually get up at 6:00 a.m., but now I’m trying to get up at 5:00 a.m. to take the medicine. But I usually don’t make it up that early. Since I’ve been on Synthroid, I’ve had a problem losing weight. I can’t keep the weight off. It’s so uncomfortable to be heavy—old clothes don’t fit me anymore. I’ve been healthy all of my life, but now I’m obese and it’s not good going into old age carrying so much extra weight,” I complain.

“Are you using the cream?” she asks, giving me an encouraging smile.

“I’m not using anything, especially now that the Women’s Health Initiative findings came out. I’m afraid to use anything,” I explain.

“Well, the first thing you need to do is take the saliva test. And one of the benefits when I started taking the Progesterone cream is that I lost 10 pounds,” she confides. Because when estrogen is very dominant in your body, your body tends to balance things off by keeping fat in the mid-area of your body.”

“Wow, I am carrying weight in my stomach. I have a belly and I never had one before!” I exclaim, wondering if maybe there is a connection here.

*But my situation might be different. My weight problem might be the result of eating too much ice cream and M&M’s while studying late at night.*

“Well, it must be because of that [estrogen dominance],” she states, matter-of-factly. “I would strongly suggest, because of personal experience, that you go ahead and have a saliva test, because that way you know exactly how much you need from the cream and then start the cream. You will be amazed.”<sup>4</sup>

“Did the doctor give you a specific dosage to take?” I inquire. “I’ve been to the health food store and have seen the bottles of progesterone cream, but I don’t know how

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<sup>4</sup> Later in the day, after I have left Bunnie’s home, I remember that I took a saliva test a long time ago, when I first started struggling with severe hot flashes. I had read a book by Dr. Lee, a proponent of natural methods of HRT, who suggested that progesterone cream was the panacea to help alleviate the symptoms of menopause. His book suggested that taking a saliva test was the first step to a proper diagnosis. The home saliva test was expensive, costing about \$200 in total, but it was bundled in with several other tests. I remember I had to chew a piece of gum to work up enough saliva, then spit into a tube and mail the specimen to an out-of-state lab. I received a printout of the results a few weeks later, along with the name of a physician in the Brandon area who practiced natural methods of medicine. My results showed that I had very little progesterone and estrogen in my body. I didn’t act on the results, because I didn’t know if the test was accurate, nor did I understand what the test results meant in terms of my overall health and menopause. I also did not phone the physician for an appointment, because my student health insurance policy didn’t cover these types of services. I paid for the test on my own, using student loan money, and afterward I regretted spending so much money on something that had no apparent benefit to me. This is probably why I forgot about taking the saliva test.

much progesterone is in the cream. So I wonder if your doctor gave you a prescription for a specific dosage, or sent you to a pharmacist—a compounder who could mix a specific dosage for your unique needs.”

*I used to take 100-milligram tablets of Prometrium, which is considered natural progesterone in soft pill form, while I was using the Climara patch to deliver estrogen into my body. Now I wonder why I needed such a high dosage of progesterone. I recall that Dr. Lee told me that doctors practicing traditional medicine gave their patients too much progesterone. Did I need a larger dosage because the pill was metabolized through my liver? I wonder about this and the ongoing debate over “natural” vs. “synthetic” HRT. Prometrium is considered “natural,” but how does it compare to the cream?*

“Based on the imbalance that you have with your hormones, [the doctor] will determine how much you need of the cream,” she continues. “In my case, I use one full pump in the morning and one full pump at night. But since I now feel balanced, I am using only one full pump of progesterone cream at night.”

“Do you purchase your progesterone at a health food store?” I inquire.

“Yes, you don’t need a prescription. Pro-Life has a nice version that is standardized. That’s the key to taking this cream. Many of the other creams on the market are not standardized in their dosage,” she explains. “I’m taking 40 milligrams a week, but I used to take 40 milligrams every day. Linda, taking this cream will benefit you in so many ways. Your hair, your skin, your mood, your energy, and it will also regulate your period and the amount of water that you’re keeping.”

“I am retaining water,” I confide.

“I also used to wake up soaked, but I don’t anymore,” she nods at me, knowingly.

“Now I’m through menopause, because my period has stopped,” I state.

“Then you will need a different dosage.”

“But I still get terrible hot flashes. Sometimes they are so uncomfortable that I have a hard time teaching, because I’m so hot. I can’t stand it,” I explain.

“You’re burning from inside,” she interjects.

“Yeah, it’s like I want to get out of my skin. I want to leave my own skin. I was working out regularly for a while. I mean really working out and losing some of my weight, but I still got hot flashes regularly. The exercise didn’t seem to help me. So I don’t know if the hot flashes are caused by nerves or stress,” I state.

“You need to start that cream,” she states, in an encouragingly voice. “I really felt stressed too, but the cream helped me stay more calm because it controls the mood swings. And if you don’t get the hot flashes, you don’t feel so irritated,” she explains.

*It would be so nice to be through menopause, I think to myself. I wonder if I should try this cream. Wouldn’t it be nice if something as simple as a topical cream that appears to be less harmful would alleviate my uncomfortable symptoms of menopause? And I wonder if taking the cream would help me head off some health problems in the future. I just don’t know what is the right thing to do here. I ponder my situation.*

“How do you apply it?” I inquire, curious about whether this treatment could actually help alleviate my severe hot flashes.

“You apply it to the tender skin on your body, so one time you use your arm, and then another time you can do it on your breast. I don’t do it on my chest because mine will hurt me. So I go to the other arm and then to the inside of my thigh, and then to the

other thigh. There are receptors in the skin,” she explains, confidently. “So when you apply the cream, it’s like a keyhole and a key. It goes right in. The cream works like a key. So you have to wait for the receptors to be free again in order to apply the cream there again. That’s why you have to switch the places in your body every time you apply it. It’s a very good thing to do,” she concludes, smiling at me in earnest.

*She is so sweet, and wanting very much to help me out with this dilemma. How can she trust non-traditional medical remedies so easily? I wonder about my distrust for non-medical and medical remedies. What a conundrum I have placed myself in here. I don’t know what to do to stay well and healthy in the future.*

“My hot flashes are not small flashes.” I state. “You wonder who came up with the term “flash” as a label for the heat we feel.” I chuckle. “Probably a male!” We laugh. “I actually timed my flashes in the past, and one flash, well, maybe there were a bunch of them coming at the same time, but one of mine seemed to last 3 hours! I guess they were probably not all one flash, but I experienced them as one long and continuous, uncomfortable surge of hot, hot heat. I keep the air in my apartment at 68 degrees, otherwise I’m not comfortable. I can feel the difference if I set the air to 70 degrees. That’s too hot for my comfort level. I can’t be around too much heat these days. Oh, my God, I can barely stand my hot flashes. They almost drive me crazy.”

“I know,” she says comforting me, “they are awful. It’s like having internal combustion in your body.”

“You feel like you are burning up and can’t get relief.” I concur.

“Do start the cream,” she implores. “And read Dr. Lee’s books. They will give you the whole scientific explanation.”

“Oh, that breeze feels so good!” I interrupt. As if on cue, heat has surged through my body.

“I love it, too,” she confesses.

“You, too?” I inquire, surprised.

“I’m a tropical girl, too, you know,” she laughs. “I highly recommend the cream,” she continues. “I thought there was something really wrong in my life and I wasn’t sure if it was emotional or physical, or a combination of both. I didn’t know why I would start crying and crying. I went to see a neurologist. It was awful. It was a really dark time for me because I thought I had something wrong. My hands would shake. And I was wondering if it had something to do with my blood sugar, because I have hypoglycemia. That is why I am so conscientious about my eating habits all day long. I have to keep my blood sugar up all of the time, even though the clinical tests doesn’t show it, I have all of the symptoms. I go crazy if I don’t eat at certain times,” she explains.

“What happens?” I ask.

“I would grab the food out of my kid’s hands. I really get into an emergency mode. My body starts to shake inside and I get desperate. I need to eat, literally. I don’t go for sugar or simple carbohydrates, but go for a combination of complex carbohydrates and protein with a little bit of fat,” she states.

The teapot whistle tells us it’s time for tea. Bunnie pulls down two cups and saucers from the cabinet and sets them down on the kitchen table. She lays out silverware and fills a plate with small pastries.

“So, for example, like maybe you will eat a piece of cheese on whole wheat bread?” I ask.

“Yes, exactly, and maybe a little piece of fruit, or I’ll have a half of sandwich and then a little fruit or some juice or tea. But I have to eat 6 meals a day, and pace myself throughout the day. In my car, I carry notes and dry fruits,” she explains.

“You carry notes?” I ask.

“Oh, there is my accent again, getting in the way! I carry n-u-t-s and dry fruits, or crackers and peanut butter and cheese,” she explains.

She pours me a steaming cup of tea.

“Mmmm, I love your tea,” I interrupt, taking a sip of the deliciously brewed Persian tea she has placed in front of me.

“Thank you, Linda. Add a little brown sugar to bring out the flavor,” she offers.

“No, thanks,” I explain, not interested in talking about my weight problem once again.

“Anyway,” she continues, “I was so distraught. I couldn’t lose any weight, no matter what I tried. I was running every day. I was watching my diet. And because my sons were allergic to milk and eggs, especially the older one, our diet here was so much healthier. We don’t even drink sodas at home.”

“What?” I ask.

“Pepsi, Mountain Dew.”

“Oh, sodas. Okay! I thought you said sawdust!” I laugh.

“That is my eternal, unavoidable accent,” she laughs. “But I was feeling awful, I would cry for no reason. And I wasn’t sleeping well. I was getting hot flashes and

waking up soaked, getting vaginal dryness and my period was hurting me. All kinds of things. My nails were brittle, and I've always had strong nails. My hair was falling out. So then I started with the cream and it was like magic! My life got together, I lost weight, I felt happier and energized. Now I go, go, go all day, and it's 9 or 10 o'clock at night and I'm still going. I couldn't do that before I used the cream. By 7 or 8 o'clock I wanted to hit the bed with the kids."

"Excuse me, Linda, I'll be right back." Bunny runs out of the kitchen. I hear her footsteps pounding up the hall stairs. She returns a few minutes later with a bottle of the progesterone cream, packaged in a cool-looking white bottle. She reads the instructions to me.

"It says here that for menstruating women, apply once a day at bedtime on days 12 through 27 of your cycle, or as recommended by your physician. But for menopausal or post menopausal women, like you, Linda, apply once a day at bedtime for 25 consecutive days, followed by a 5-day break or as recommended by your physician. So, let's say you start the first day of the month, you count 25 days and then you stop for 5 days. Then you start all over again," she explains to me. "This brand, Life-Flow progesterone cream, comes from wild yams. But it's standardized, as I mentioned earlier, to 20 milligrams for one full pump. And it has other ingredients in it like aloe and it's very pleasant to use."

She pulls off the cap and pumps a small dollop of the cream into my outstretched hand.

"Oh, and it doesn't have a scent," I state, sniffing the white cream in my hand. "That's nice." I rub the cream onto my inner arm. "By the way, what are wild yams?"



“See how pleasant it feels? It has coconut oil and sunflower seed oil in it, and also shea butter, which is rich in essential fatty acids and vitamins A and E. Shea butter helps to make your skin really soft,” she explains. “When you take this cream on a regular basis, your body is going to start to stabilize. Even your adrenal glands get affected, because hormones regulate the whole body. And your thyroid will improve too.”

“It does feel smooth on my skin,” I marvel to her. “Are the wild yams from the vegetable?” I ask her again, only this time I am distracted by the savory smells of balsamic rice, chick peas, and prunes that have been steaming since I walked into her kitchen. “Is it time to eat? I’m starving!”

“Me too. I’m glad you mentioned that, because I was waiting for your cue,” she confides, getting up from the kitchen table. “We’re going to have a traditional Persian dish that I cooked without meat. It normally is made with lamb, but I thought you wouldn’t want to eat any meat. And I’m going to treat you as if you were part of my family.”

“Oh, I prefer that!” I exclaim.

“So we’re going to eat on our regular kitchen plates.” She begins pulling down plates from the cabinet, examining each, looking for two that do not have cracks in them. “We’ve had these plates for 10 years now, and I use them daily. They have held up pretty well, but when we remodel the kitchen I would like to get new dishes.”

While she chops a cucumber, I set the table.

“I’m making a Persian salad. It’s very simple,” she explains. “It’s made with cucumber, yogurt, salt and pepper, and crushed mint.”

“This dish reminds me of a Greek dish called skordalia. It’s made with a lot of garlic and potatoes mashed together, and it’s a spread you can put onto bread. But when you eat skordalia, you reek of garlic for several days!” I explain. “I don’t mind, though, because I love garlic.”

“So do I. We do this dish with garlic too, and we do it with spinach.”

“Oh, that’s another good Greek dish. We call it spinach and rice,” I state.

“I know about that,” she says.

“Your cooking is not too different from the Greeks,” I conclude.

“Here we go,” she says, “a traditional Persian meal.” With a ceremonial swirl, she places a large platter onto the table. The platter is filled with cooked rice shaped like a huge loaf of bread. The outside of the loaf has a crusty, crispy-looking golden outer shell. But she tears into the outer shell to reveal a soft and creamy interior to the loaf of rice. She places a huge dollop of the steaming rice onto a plate, adds cooked prunes to the top, scoops some warm juice over the rice, and adds a garnish of two cooked limes to the side before handing me the plate.

“Take the tabek,” she explains, “the crust of the rice, with your hands, like this,” she breaks a thick crust of golden rice off the loaf.

We begin to eat and continue our conversation about the benefits of progesterone cream and menopausal symptoms. I use the tabek to sop up some of the juice from the steamed limes while we talk.

## Anna's Story

I'm driving south on I-75 this Saturday afternoon, on my way to meet with Anna for a 2:00 appointment. I met with her once before at a restaurant called Sweet Tomatoes. At that time, she signed the consent form, but we couldn't conduct our first interview at the restaurant because it was too noisy. So she invited me to her home for our first interview. Earlier this morning I was working with a colleague on a panel submission to our national professional association. I left my friend's place around noon with plenty of time to get something to eat before my appointment. I'm driving at a nice clip and am happy that I'm on schedule. My mind wanders back to the recent flurry of telephone and face-to-face interviews I have had. I recall that one of the women I spoke with was not very verbal, and at the moment I can't seem to remember if that person was Anna. And because my participants need to be verbal enough to share information freely with one another, I am worried that my appointment today might not turn out well. But, I reason with myself, I'll just cross that bridge when I come to it.

Familiar blasts of heat curse through my body at regular intervals as I drive down the expressway. I left the house this morning without eating breakfast, because I was running late for my morning meeting. And now I'm very, very tired. I wonder if there is a connection between hot flashes and exhaustion. I also wonder if my severe hot flashes are a function of my poor eating habits. I dictate a note into my tape recorder to ask a physician about these connections sometime in the future.

Suddenly, taillights flash red in front of me. I slam on my brakes and come to a stop just past the Mango exit. I notice several cars slowly backing down the expressway, hugging the right shoulder. They swing around and speed off the Mango exit. I think they are smart to get off the expressway, but since I'm not familiar with this area and don't have a map in the car, I decide to stay the course and wait for the traffic to move again. It shouldn't take too long. I've driven this expressway many times and I've never been in heavy traffic for very long. But after forty-five minutes, I am still standing in the same spot on the expressway. I haven't moved an inch. I don't own a cell phone, so I can't call Anna to let her know I will be late for our meeting. My worry kicks in.

*Will she still want to meet with me today?*

*Will she be willing to reschedule our appointment?*

*Will she think I'm a flake?*

*What if I lose her as a potential participant before I have a chance to meet her?*

*Oh, I'm so hungry.*

*Why didn't I eat earlier?*

*If I don't eat soon, I'm going to start shaking.*

*I wish I had brought a piece of fruit with me.*

I peer into the fanny pack sitting on the passenger seat, hoping to find a piece of gum or candy to help me through this rough spot. But all I see is my wallet, a wad of facial tissues, a couple of red pens, a few pennies, and a bunch of lint. Another surge of heat moves through my body at lightening speed. I turn the air conditioner knob to the maximum setting and fiddle with my tape recorder, waiting for cool air to wash over my skin. I press the playback button on my recorder, and try my best to focus on the running

stream of thoughts I've been dictating into the microphone. My voice sounds clear and loud. Everything seems to be working well.

Suddenly, my Escort rocks back and forth, and I look up just in time to see the taillights of a squad car zoom past me, driving on the right shoulder. A few minutes later my car rocks again when a flatbed tow truck speeds by on the shoulder. So now I know that there has been an accident up ahead. A little while later, traffic begins to snake forward at five miles per hour. After idling forward for a few hundred feet, I see several police officers standing in the far left lane directing all of the traffic to merge into one lane. There is something sprawled across the road, lying belly up like a beached whale. I think it's an RV, but am not sure. Shards of glass are scattered across all four lanes of traffic, and although only one squad car passed me on the road, there are at least three additional squad cars at the scene along with several tow trucks. I don't see any other cars around, nor do I see an ambulance, but nevertheless, I wonder if anyone has been seriously hurt.

I swing off the expressway at the next exit and stop at a Bob Evans, the first restaurant off the highway. I hastily place a call to Anna letting her know why I'm running so late. She is very gracious and says that it's okay for me to drive out later, after I've had something to eat. I wolf down a salad and get back on the road quickly. By the time I roll up the circular driveway to Anna's home, it is 4:00 p.m. I am two hours late for our appointment!

"Hi, Anna! I'm so sorry I'm so late," I grin sheepishly.

"That's okay," she smiles. "I've been cleaning. I didn't have anything else to do today," she chuckles. She steps aside to let me into the foyer of her home.

“Oh, your home is so beautiful!” I exclaim, startled at the view from the entranceway. My eyes sweep past the formal living room decorated in muted shades of beige and rose, to an expanse of floor-to-ceiling glass windows on the far side of the living room and to the pool area beyond. The deep azure water shimmers and glints from sunlight streaming in through the windows. The environment is so serene, that I feel like I have just stepped into a resort instead of a home.

“I love your pool area!” I exclaim. “Did you and your husband design your home?”

“We kinda changed the model around. We pushed a wall out a little and changed the windows,” she explains.

“You have a wonderful sense of space in here. It’s beautiful.” I slip off the purple-with-black-trim nylon running jacket that I am wearing. This jacket served as an additional layer of warmth when I exercised outside on icy, winter days when I lived in Illinois. It now serves mainly as a reminder of the fit person I used to be, before I stopped working out. “Where should I put it?” I ask her.

“It’s so cold outside. I had all of the windows open earlier, but all of sudden it got too cold.” She takes my jacket and hangs it on the coat rack tucked away in a corner of the entranceway and motions for me to sit down at the dining room table.

The dining room, located to the right of the foyer, holds a few pieces of furniture. The square, wooden dining table covered with a pink cloth and the four matching chairs are the focal point in this room. A tall hutch decorates one corner, and a small table stands against the far wall. Sitting on top of the small table are several framed pictures of

two young adults. I assume these are the two children she has mentioned to me in the past, a boy and a girl.

“Yeah, I didn’t expect it to be so cold today either,” I agree, dropping my car keys into my fanny pack. I lay my large tape recorder on top of the dining room table. The cassette tape enclosed in the unit has been capturing our words since the moment I entered Anna’s home. “I think it was much warmer this morning,” I observe, pulling a fresh spiral note pad out of my briefcase. I slip a hand inside the briefcase looking for a pen.

“Did you get some lunch?” she asks.

“I did. I ate at Bob Evans,” I explain. “I didn’t want to eat there because I know their food isn’t the healthiest, but it was close to the highway.” I fiddle with a corner of cellophane that is tightly wrapped around a blank tape. It’s difficult to pry open the edges of these cellophane wrappers, so I usually get a head start on this process before leaving for my interviews. But I didn’t have time to unwrap the blank tapes before leaving home this morning.

“Good old Bob Evans,” she laughs. “Grandma and Grandpa used to take our daughter there when she was little. She used to call it “Bob Heavens.”

“Cute!” I interject. I finally catch the corner of the cellophane and begin unwrapping the clear plastic.

“So, that was our standing joke. We always went to Bob Heavens!” She lets out a chuckle.

“That’s darling,” I exclaim, smiling.

We sit down at the table, and, after arranging several spare tapes, a spiral notebook, two pens, and my list of questions in front of me I decide to check my tape recorder to ensure that our voices are loud enough to be recorded. My voice vibrates and booms through the speaker loudly and clearly. I move the tape recorder closer to Anna to ensure that the microphone will pick up her very soft voice.

“Thank you, Anna, for seeing me today,” I begin. “I want to talk with you today about your life. I want you to tell me whatever you would like to tell me about yourself.”

“About myself?” she questions, unsure of what I’m asking of her.

“Yes, tell me whatever you want to tell me about yourself. If you were telling someone a story about yourself, what would you want them to know?” I ask, hoping to encourage her to talk as freely as possible.

“Gosh, I have not had to talk about myself in a long time. Hmmmm, well, I guess if I look at myself, first and foremost I think of myself as a mother,” she explains. “I guess that is because being a mom has taken up so much of my life. I’m at the end of that now, because my kids are able to take care of themselves now. One of my kids is 25 and other is 19.”

I marvel at how young she looks. She is slim and small-boned, probably no taller than 5 foot 4, with light-brown, curly hair framing chiseled features. She is dressed casually in a rust-colored tee shirt and form-fitting jeans. She doesn’t have a line or a wrinkle on her face; definitely too young to have a 25-year old child, I think to myself.

“My youngest is ready to go off to college next year,” she continues, “so she will still be a part of my life for a while. My son is off in Miami, and I miss him, but we see him quite a bit, so that is working out. Let’s see. I’m a nurse. That defines me more



right now, because I seem to spend more time doing that than anything. In fact I left work last night at 7:00 p.m. My job has gotten busier, because I'm learning a new job. I was born and raised in Nebraska. I lived there for 21 years. And then I married a military man. We moved around until we came to Florida in the mid-eighties. And we have lived down here ever since. Recently, we've divorced in August, so my life has really changed totally."

"You have been through a huge change!" I exclaim.

"Yes. We were married for 30 years. So, it's better now, but it's harder for me. I've been trying to take care of this house by myself but I don't intend to do it for much longer. I'm hoping to find a little townhouse up north if I can sell this place sometime later this summer," she explains.

I tick off the recent stressful changes in her life. "Let's see, first you were divorced, and now you might uproot yourself by moving from the home you have lived in for about 18 years. That would be another huge change in your life. And in addition to this, your children are leaving the roost. All of these changes are extremely stressful, Anna. I think that you are coping well."

"I think I got through the hardest part when my son left," she confirms. "It was very difficult. I missed him so much. Of course, my husband and I were going through difficulties then too, so, ah, I was just—probably menopause was also a part of it. I was very weepy when my son left. I was busy working, but the menopause, the emotions and all of that may have been a part of it too."

"How did you come to realize that you were going through menopause?" I ask.

"Tell me about it."

“I don’t think that I had even recognized it until I was at one of my yearly check-ups. My doctor said to me, ‘you ought to be on estrogen.’ I suppose I was in my late forties and my periods had already started to change a little bit. They had not stopped, but were just changing. I wasn’t ready to be told I was going through menopause. I had not even thought about it. And my attitude toward it had always been that it couldn’t be that big a deal. So, I really did not want to start taking estrogen. I really didn’t, and I discussed it with my gynecologist a number of times. She kept insisting that it was very important that I take it and it would prevent me from getting osteoporosis and heart disease, both of which run in our family.”

“Why didn’t you want to start it?” I ask for clarification.

“Well, I don’t like taking medicine. I’m a nurse. So I read everything I could about it and it just sounded unnatural. If we’re going to end [menstruating], well, it seems to be natural to just let it end. I felt that there were too many side effects, and I didn’t want to deal with that. And I didn’t feel like I needed it yet. Probably denial is what went through my mind initially. And I wear contacts and everything I read said that it might interfere with that and I didn’t want to have that as a problem too. But I started taking it, and I guess I took it for a couple of years, two years, maybe. And then a study came out. No, my timing must be wrong. I was probably over 50 or maybe 51. And as I took it, I finally started to slow down. I never did stop [menstruating] entirely until I finally stopped taking estrogen. But the whole time that I took it I was not happy. And as soon as that study came out,” she claps her hands together hard, “that was my ammunition to quit!” She smiles and leans back in her chair.

“Did you quit on your own?” I ask.

“Yes, I called them [the doctor’s office] and told them I was going to quit. But I had, of course, already quit.” She throws her head back and laughs heartily, pleased with her actions. “And they told me, ‘fine, if you don’t have any problems going off it cold-turkey that’s fine. But if it bothers you take it every other day, then every other week, and see how,’ well, I hadn’t had any problems, and I hadn’t really gone through the hot flash business, maybe a little, but it didn’t bother me that much, so I was happy to stop. But not long after we were going through our divorce.”

“So, you were going through a real rough time,” I interject.

“Not long after stopping the estrogen, I just felt very depressed and as I said earlier, very weepy. I would just turn on the tears anytime I thought about the problems we were having, the kids, or anything, so I thought maybe I should go back on estrogen just to help me out. I talked to my doctor again and—”

“Oops, kitties are visiting us!” I interrupt, feeling something soft rub against my leg. “I’m allergic to cats, so I try to be careful not to touch them, even though I love cats. I’ll stay still, and hope the cat will decide to move on.” I hear the sound of purring near my ankle.

“We have two cats. This is Mickey, he is usually very skittish, so I guess he has gotten used to you. Hey! Mickey,” she yells out.

“I have a cockatiel named Mickey,” I explain. “My mom’s taking care of him for me. So he is with his grandma.”

“These are my daughter’s cats, but you know who takes care of them,” she confides, laughing. She stands up and claps, and Mickey disappears into the living room.

“So, you called your doctor,” I continue.

“Yeah, I stopped taking the combination which was in the study.”

“Was it Prempro?” I ask. “Prempro was implicated in the Women’s Health Initiative research study.”

“Yes, that’s it. That’s what I had been taking. So, the doctor gave me two pills. She gave me a lower dose of estrogen and, what was the other called?”

“Prometrium?” I interject.

“Yeah. I did that for a little while, thought I felt a little better, but still was not happy about taking estrogen. About this time I went to see another gynecologist who gave me a little patch and also gave me a number of options,” she explains.

“Oh, that’s right. I remember you telling me you took the Vivelle-Dot. I took that too. I liked that little dot! It was nice and small,” I exclaim.

“It was very easy to use. And I still didn’t see much difference, but the gynecologist gave me a number of options when I talked with her and one of them was an antidepressant; I had a choice of an antidepressant, all the herbal products on the market, nothing, vs. a lower, much lower dose of estrogen. She gave me prescriptions in fact. I had prescriptions for one higher dose and one lower dose of estrogen. So I tried both of those and still didn’t see much difference. So I went back to my primary doctor and told her I thought I would try an antidepressant. I’ve been on it for almost a year now, and it’s working for me.”

“How often do you visit your doctor to make sure everything is okay?” I ask.

“I’m on an antihypertensive medicine too, so I see my doctor about every four months. I haven’t shed a tear lately and all through the divorce too. My divorce was in August, but I started taking the antidepressant last spring.”

“That’s great! It helped you,” I state.

“I’m on a fairly low dose and I sleep better. But it took a while. And they say that is the case,” she explains.

“It takes around 30 days, right?” I ask.

“It took me longer than that. But I’m finally sleeping better. I used to have trouble with night sweats but that has subsided,” she confides.

“Do you plan to stay on it for a while?” I ask.

“The doctor told me to stay on it for at least one year, but I’m getting close to that anniversary. I’m going back to her in June,” she explains.

“And you might stay on it?” I inquire.

“I don’t know,” she states.

I think about my own problems with menopause. “I too had a difficult time,” I confess. “I walked around like a zombie, weeping constantly. It was so embarrassing. I remember one day running into one of my professors in the department. She was sweet and very observant. She could see that something was wrong, so she gently asked me how I was, and I burst into tears. I started blubbering right there near the mailboxes in the department. So there I was, sobbing with tears streaming down my face and in between my sobs I would say, ‘I’m really okay, honestly I am. I’m just a little emotional these days.’” I laugh at the recollection. “I’m sure she wondered if I was sane. In fact, I’m sure the faculty thought I was out of my mind, or at the least the most emotional person they had ever met!”

We chuckle.

I continue my story. “The gynecologist I saw also wanted to give me an antidepressant, because I was having such a difficult time with hot flashes. She said that antidepressants appear to help some women through this difficult time of their lives but since I wasn’t under her care full-time because I was a student, I was afraid to take a drug that alters my brain chemistry without having someone monitor me. I had originally seen this particular gynecologist because I had begun to bleed every day, so the nurse practitioner at the Student Health Center referred me to a specialist. The gynecologist surgically removed a huge polyp from the middle of my uterus and my bleeding stopped immediately. I haven’t had a problem with uterine bleeding since then.”

“I think you were right not to play around with antidepressants. There was an article in the paper just last week about the number of young adults, teenagers who are taking the new antidepressants. They are called serotonin uptake and apparently they are causing more depression and suicides,” Anna explains.

“Ahh choo! Ahh choo!” I sneeze.

“Oh, it’s the cats. I’m so sorry,” Anna states.

“I’m usually okay if I don’t touch them. Ahh, ahh, ahh, I stifle another sneeze. I’ll be okay,” I rummage through my fanny pack for a tissue.

“Would it help if I put the cats outside,” she asks.

“No, no, I’ll be okay,” I sniffle.

“Yeah,” I continue our conversation, “but that article was about younger adults, not older people.” I take in a deep breath through my mouth. “And the doctor I saw did say that antidepressants do help women going through menopause,” I state, sounding very nasal.

“I do have a few friends who have taken it at different periods in their lives and it has helped them too,” Anna confirms.

“Do you think your weepiness had anything to do with the major changes you were going through with your partner?” I suggest.

“That’s what my husband thought. But I don’t think so. I think going through these changes gave me the courage to end our marriage. Our marriage had not been good for years, and five years ago I told him I was going to leave him. So that was long before I started menopause. But he thinks it has something to do with it. The weepiness didn’t start until after he left and we had so much trouble deciding what to do. I feel stronger now than I did then. I made a decision that I had not been able to make for along time. I don’t know if lack of estrogen helped me through that or not, but I’m certainly glad I did it.

“Now that you are going through menopause, do you feel like you are making different decisions or more decisions than you did before?” I inquire, curious how she sees this stage of her life.

“I’ve never been on my own. This is the first time I have had to experience that!” She confides.

“How old were you when you married?”

“Almost 21. I went to college for a couple of years and moved home until the day I got married. So I went from my folk’s house to my husband’s house. In our day, you went to college but you got married. All of my friends were married at 20 or 21. You were an old maid — ”

“You were an old maid at 25 or 26, right?” I interject laughing. “Well, then I’m a real old, old maid!”

We chuckle.

“But really, this is the first time I’ve had to do everything for myself, and I like it. I’m overwhelmed at the moment because of this house. There is so much to do to keep it up. It’s a real money drain too. But I’m really looking forward to having my own place and taking care of myself. I would much rather have a little place and be able to travel. That’s what I hope to do. I hope to have time to do that or to do something else besides work in the house. It takes so much time. We used to spend our weekends maintaining the house, him on the outside and me on the inside. We didn’t do much of anything else.

“I’ve heard people say that what’s important are the regrets you think you might have on your death bed. I don’t believe anyone on their death bed would be saying, ‘oh, if only I had had the time to wash those windows!’”

We laugh.

“Exactly! That is true. It doesn’t make sense to spend so much time on the house.”

“You didn’t feel you were prepared for menopause, right?” I ask. “That was one of your concerns when the doctor told you to take HRT.”

“No, I didn’t think it was time yet. You don’t feel as old as you are and then my daughter was, I’m trying to remember how old I was. Let’s see, 47 and she was only 10, so it must have been after 50 when I started feeling like I was going through it, because she had not started to menstruate as of yet. And I started thinking, ‘oh, my gosh, I can’t be ending before she even starts!’ And that’s when I really noticed that something



different was going on and that I might feel kinda uncomfortable with this. I felt it was just going to be a part of life and I wasn't going to let it affect me and I didn't know anybody who really had had it affect them. I had heard people talk about hot flashes, but big deal. But when I thought about my daughter being that young and me being that old, that bothered me. So fortunately she started [menstruating] as soon as she was 13 and it stopped bothering me because we got to talk about it together. We got to share that for a while and now I just laugh at her and say, 'ha, ha.' And she says, 'ha, ha, you're old!' But I truly did not want to take estrogen, and I wasn't prepared when she [the doctor] told me I needed to and I still don't know if it is necessary to take estrogen. I wonder, are we silly for not taking it? Are we going to end up all wrinkly if we do live to be 90? But don't we have medication for our bones and better studies to assess whether we have osteoporosis. If we are smart, we are keeping track of our hearts and we won't get heart disease. My doctor told me the other day when I was in for my blood pressure check that 50 percent of the population over 50 years of age are on an antihypertension drug."

"I read in the news that women have a higher chance of having heart problems than men!" I confide. "I was shocked. I am not on HRT. I, too, took myself off my Climara and Prometrium when the Women's Health Initiative came out, even though I think that my HRT formula was safer than Prempro. But it scared me, and I've gained so much weight. I'm scared because I don't want to get heart disease when I get older. And it runs in my family. Although I'm healthy right now, there are no guarantees for the future. And I also worry about my vagina shriveling up. I think to myself, 'Oh, boy, I'm never going to be able to have sex in the future.'"

"I've had that thought too," Anna laughs.

“I’m afraid my vagina is already beginning to atrophy,” I declare, sounding worried.

“On the other hand, my mother-in-law never took estrogen. My mom didn’t either, but she was only 65 years old when she died.

“Did she ever talk with you about menopause?” I ask.

“No, we never did. I was only 40 years old when she died. You know, the gynecologist I saw told me that for vaginal health there are creams if you need them. And of course there are lubricants,” she shares with me.

“But what if my vagina has already atrophied?” I ask.

“Do you think it would atrophy,” she asks.

“Well, I know it changes, especially without taking estrogen,” I state.

We both laugh.

“It gets dryer,” she explains.

“I read that your vagina thins out,” I state.

“By ‘thins out’ I understand that to mean that there is less moisture there. And the tissue may break a little more easily. But I had thought if you introduce moisture to it, but whether you can just do that and have sex and have it to be comfortable, I don’t know,” she ponders this. “We’ll have to test that theory sometime!”

We both laugh heartily.

“The gynecologist told me you need to use it or lose it,” I announce, smiling broadly.

“Use it or lose it! I like that,” She says.

I sneeze again and again and finally decide it’s time for me to close the interview.

## Jane's Story

Jane and I met for our first interview at T.J.'s, a restaurant near the Cheesecake Factory in the International Mall in Tampa. Taping an interview in a restaurant can be a disaster because of the background noise, but I agreed to meet at a restaurant, as this seemed to be the most convenient place for her to meet with me. We grab a cup of coffee inside the restaurant, but decide to sit at one of the hunter green metal tables outside for our talk, because the background music inside the restaurant is too loud for us to have a meaningful conversation. As usual, it's beautiful in Tampa today. The sky is blue, the air is fresh, and the palm trees are gorgeous in this part of town.

“When I told my husband that I was participating in this research, he said, ‘Are you sure they have the right person?’” She brushes a stray strand of long, dark hair off her face and lets out a hearty, staccato laugh. Her bright, green eyes twinkle.

“Isn't that cute,” I respond, smiling. “Tell him that down the road I would love to talk with him.”

“I was explaining this project to him, and I said, ‘I don't think it's from a medical standpoint. I think it's more from a psychological perspective, how you're thinking and how you're feeling standpoint.’ He goes, ‘Well, then she definitely should be talking to me, not you!’”

We both chuckle.

“Tell him I’ll take him up on that offer down the road,” I holler out. I take a sip of my hot coffee. It’s chilly today, so the warm coffee soothes me. I didn’t bring along a jacket, as I’m usually too hot. I notice that Jane is also not wearing a jacket. She is dressed in a chic-looking black slacks outfit.

“Is it too cold out here for you?” I ask Jane.

“Not at all,” she smiles. “It’s comfortable out here.”

“Okay, I have a funny story to tell you,” I continue. “I was at a Federal Express office the other day, waiting in line when a major hot flash came on. So there I was standing in line fanning myself with a piece of paper, saying ‘Whew!’ And a sweet man said to me, ‘Oh, I understand. Why don’t you go over to that fan and stand under it?’ He pointed to a fan in the center of the room. And I did. I ran over and stood under the fan, craning my neck, holding my collar open, and trying to get as much cool air down my top as I could. There were a bunch of people in line, but they seemed to understand that I wasn’t really trying to cut in front of them. The man said to me, ‘What in the world could women have done to have to go through this stage in life?’ He told me that his mother-in-law is going through menopause and she’s having a rough time too. And I thought he was so sweet to be so empathic, but on the other hand, he also seemed to be blaming women for the problem. As if we did something to cause menopause to happen to us!”

“Yeah, hot flashes are terrible,” Jane concurs. “There is no way to describe it. It’s just like fire coming out of your head. And I’m starting to have night sweats again.”

“Oh, I get those too. They are terrible. It’s horrible. They wake you up. I hate them,” I complain.

“I haven’t had hot flashes for a long time, thank goodness, but yeah, I know how horrible they can be,” she says with empathy.

“Jane, you are so young to be having menopausal symptoms.” I look closely at her dewy complexion for telltale signs of aging; a little wrinkle here, or sag there, but she has none. Her complexion is flawless. “Why don’t you tell me a little about yourself?”

“I guess background information would probably be the best place to start,” she states.

“Whatever you would like to tell me is okay,” I explain.

“Oh, let’s see, I’m 39, married, with one child who is 3 years old. After I had my child, I had some complications with moving my hands. Like putting the key in the car and cranking the car up, or putting my arms up to wash my hair. And I’m a small-framed woman,” she explains.

“Yes, you’re tiny,” I concur. She is so tiny, that I would guess her dress size to be a one or two. But I don’t ask for confirmation on this point.

“And honestly, I just thought that the problem was from my pregnancy. I never had any medical complications, never thought about it at all. So, after giving birth, I still had problems, so the doctor started to do tests and they found out that I have a condition called myasthenia gravis, which is an autoimmune disease. What they suggest you do when you have this particular disease is that you have your thymus gland out. Your thymus gland is located in your chest cavity. And in order to remove that, it’s very similar to open-heart surgery.”

I let out a small gasp at the thought of her having this type of invasive surgery.

“It’s the same full sternum split and they remove this gland,” she explains. “Mine was enlarged, so they removed it.”

“Do you need your thymus?” I ask.

“It’s large when you are born, when you are a child. Then, as you get older it starts to shrink and it really doesn’t have much function in this world,” she explains. “So they took that out and after that I did not have a period. But I didn’t think much about it. I thought, you know, well, my body just went through a major change and it’s probably just not time to have it yet. And so six to eight weeks passed and I started having night sweats. I didn’t really think much about that either.”

*In retrospect, I now realize that I started having night sweats when I was in my forties, and I, too, didn’t think too much of them at the time. They weren’t severe at the start, and they were happening intermittently. I used to chalk them up to catching a mild cold or bug of some sort. But on occasion I remember worrying about whether I had something wrong with me, as I knew night sweats could be a symptom of a serious illness. I never mentioned this to a doctor, mainly because I was healthy and didn’t see doctors on a regular basis. I was pretty dense about my body, or maybe I was simply in denial. But thinking about my body-in-menopause was just not part of my frame.*

“So, at that point in time,” she continues, “I went to the doctor and told the doctor about the problem. At that time, I thought they would give me something, because I know that sometimes they can give you something to force your period. I wanted to be on birth control pills, because I didn’t want to have back-to-back babies. I wanted a bit of space between them. And so, ah—what do you call it? Oh, I’ve lost my train of thought!”

*It is somewhat comforting to know that other women who are going through menopause also have problems with memory lapse. There have been many times that I have had a problem following the conversations in my classes, since I have entered menopause. I remember having a particularly difficult time tracking the conversation in my Ph.D. seminar on Framing and Sensemaking. I would be following the conversation, thinking about the issues my colleagues were discussing and then all of a sudden a blanket of heat would engulf my body at lightening speed and zip, bam, boom, I would lose track of the conversation. It was so frustrating constantly to ask the person next to me ‘what did she say?’ I used to take copious notes in class and try to ignore the heat cursing through my body, or the layer of sweat glistening on my forearms, but after class, I would notice that my notes were mainly half sentences of incomplete thoughts. Menopause has caused me much heartache.*

I pull my attention back to our conversation.

“You were telling me that you were getting night sweats and you went to see the doctor,” I remind her.

“Oh, yeah. So I went to the doctor and they were like, ‘Well, let’s do a test. It’s probably nothing.’ And they called me with the results of the tests and said that I was in menopause,” Jane explains matter-of-factly.

“Wow! You are so young, I mean very, very young to be in menopause,” I state sympathetically.

“I know. I was like, ‘What do you mean?’ So I did a lot of research on this, you know, trying to figure out what’s going on with this and how it related to my MG

[myasthenia gravis]. The doctors said it was probably linked to having an autoimmune disease.”

“How do you spell that disease?” I ask.

“It’s m-y—I have to write it out.” She opens one of the napkins sitting on the table, borrows my pen and spells the name on the napkin. “The myasthenia gravis part of this problem means that antibodies are latching on to my receptors on my nerve endings so that the chemical can’t get to them, or it breaks down that chemical that affects my movement. I’m extremely mild in my condition on that.”

“Does this condition give you pain?” I ask.

“It’s not painful at all. The easiest way to describe it is that if you’ve ever worked out in a gym doing, say, repetitions of ten, and on that tenth repetition it’s just really hard for your muscles to go up and lift the bar. And sometimes I don’t even key-in to this condition, because I’ll just think that I’m tired. And then I’m like, ‘Oh, yeah, maybe I need to take something,’ and life goes on. It’s very mild and hopefully it will always stay mild.”

“Is there a medicine for this condition?” I ask.

“Yes. So, the doctors think that the same antibodies basically attacked my ovaries. And that’s what caused me to be in menopause. At that point in time, I started taking hormone replacement therapy. I’m still on it. The first thing they put me on was Prempro,” she explains.

*Prempro was implicated in the Women’s Health Initiative study. I too was on Prempro for a short time. That was the first HRT formula that Marsha, the nurse practitioner at the Health Center, gave me. I stayed on it for a few months but didn’t*



*tolerate it well. My breasts became swollen and achy. I felt like I was lugging around two ripe watermelons. And I became very weepy and moody. Then I began to bleed, and I bled every day, so I called Marsha, crying, and told her I had thrown away the Prempro. She switched me to a two-pill regimen of Premarin and Provera, and I bled every day. I took those pills for about ten days, before tossing them. And I called the Health Center again crying, still bleeding every day, and experiencing terrible hot flashes. She then prescribed Activella, which didn't work either. Activella gave me neurological symptoms within a few days of taking my first dose. I developed headaches daily and had trouble seeing, so I tossed those pills too. She finally gave me a referral to a gynecologist.*

“It didn't work at all,” Jane continues. They changed me around several times. I remember one day driving on Gandy Boulevard, and at one red light I just wanted to kill the driver in front of me. And at the next red light I was almost in tears. I'm just not that kind of person and had never experienced PMS to a large degree. And so I called the doctor and went, ‘What have you people done to me—I'm psycho!’ So they changed me around several times. And that's when I read in the paper about the seminar on menopause and the results of the Women's Health Initiative. I'm still on hormone replacement therapy, but I'm on compounded hormones now.”

“That means a pharmacist has mixed the hormones for you, right?” I ask.

“Correct. My gynecologist writes the prescription and then I take it to one of the compounding pharmacies here in town.”

“So, he compounds an HRT formula for you, a combination of estrogen and progesterone, right? But then you told me you are taking something else too.”

“Right, I’m on an HRT combination and I’m also on Cenestin, which is an estrogen,” I think. I just picked up my prescription from the compounding pharmacy and I forgot to bring that today. I’m so sorry.”

“No problem,” I respond. If you have a chance, get that information for me, but it’s not a big deal. I don’t need to know the exact formula you are taking.”

“And I’m still playing around with that a bit. I was doing so much better when they put me on this, but I’m not back to being 100 percent of who I am. But I’m so much better from the disaster that I was when I was on the Prempro. It gets to the point where it’s like, okay, if we start messing with this medicine I could go back to being loony again. You know, let’s just leave it alone. So I left it alone for a while and I was still having mood swings. And so now they have put me on a mild antidepressant to go along with my HRT, which seems to be helping. And I just started that. I have a doctor’s appointment in a couple of weeks and I want to talk with them about my options and what that can do long-term and all of that.”

“Who gave you the antidepressant, your internist or your gynecologist?” I ask.

“My OB-GYN. It took me a long time to find a good doctor. I was happy that someone finally understood how all of these puzzle pieces were put together, because before I met my current doctor, I would go and meet doctors and they’re like, ‘Oh, how interesting.’”

“They didn’t know what to do,” I confirm.

“They would be like, ‘Yes, we have read about you,’ or ‘We’ve read about MG before.’ If you go onto the Internet you’re going to come up with horror stories, but it’s really not a horror story in my life at all.”

“Well, my thyroid closed down since I have been here in Tampa working on my Ph.D.,” I confide. “I’ve always been healthy, so having a thyroid condition was a shock to me. I didn’t realize I was sick for a long time. I started feeling poorly, and my hair began to fall out. I gained weight and was having trouble thinking and, as I mentioned, I was having horrible hot flashes. I became so weak I had difficulty lifting a pan of water. I had to use both hands just to get a pan of water onto the burner. I was constantly winded. And my throat felt sore. One day, I was at the library and reached up to take a book off a high shelf. When I tipped my head back, my throat felt sore, so I put my hand on my throat and I felt a lump in my throat. I thought, ‘Oh, my God! I have a tumor in my throat.’”

“Bless your heart.”

“I don’t remember how I made it to the health center. But the doctor ran tests and we discovered that my thyroid numbers were abnormal. He sent me to Tampa General Hospital for another test where I had to swallow a radioactive isotope and then return the next day for a scan of my thyroid.

“Yeah, I had that test too,” she confides.

“Well, the next day when I returned for the scan, while I was lying on this small table having the scan, the technician ran into the room wanting to know what I had eaten the night before. He wanted to know specifically if I had eaten any sushi. It turns out that I had no functioning thyroid. What a shock it was to realize that my thyroid had closed down. And I wasn’t placed on medicine immediately either. The health center doctor said I had to see an endocrinologist first, and I think I called every endocrinologist in the Tampa area, but couldn’t find a doctor who could see me within a reasonable

length of time. I was panicked. My major professor's wife is a retired physician, and she helped me get an appointment with an endocrinologist that she knew. I was so exhausted during this time of my life. Every day I would drag myself to school to teach or to attend my own classes. I used to get winded and feel dizzy just walking up a flight of stairs in the CIS building, where I taught and took classes. It took about 6 months from the time I was diagnosed to the time I began taking Synthroid. And it took even longer before I began to feel strong again. I now wonder if my thyroid problem might have been related to menopause or vice-versa, or to the fact that I put myself on and off several types of HRT formulas in a short period of time.”

“Right,” she confirms.

“And once I began feeling better, I wanted to try to go off the medicine to see if my thyroid would function without the medicine. But the doctor said we had to test for antibodies first. I had had an antibody test when I was first diagnosed. The Health Center doctor had ordered that test, so I didn't understand why I had to have another antibody test. But I guess there can be a lag between the time you develop thyroiditis, that is what I had—non-specific thyroiditis—and when the antibodies show up in your body. The endocrinologist told me that if the antibody test was negative I could slowly wean myself off the medicine; otherwise, I could never go off this medicine for the rest of my life. And wouldn't you know, the test came back positive. So I wonder now about those antibodies. I think my body attacked my thyroid and that's why I have certain antibodies in my body. I wonder if this means I have an autoimmune problem, too—similar to you.”

“I kick myself when people ask me medical questions about my condition,” Jane explains, “because I feel so uneducated too.”

“Well, how can we know everything?”

“I got all of my education at the time I was diagnosed,” Jane states, throwing her hands into the air for emphasis. “At the time I was going through everything I had tons of information—I knew it all. Just from talking with the doctors and reading about it online, you know, the whole nine yards. I could tell you everything. I had a running file—everything. It was the same when I went through menopause. I could tell you all the dosages and everything I was on. But I don’t do sick well.”

“I don’t know who does,” I concur.

“I don’t have time to be sick. And so now people ask me and I’m like, ‘I don’t know.’ It’s because mentally I can’t go there anymore. I learned what I needed to know at that point in time, and now I’ve decided that the problem is solved and life goes on.”

“Me too. When I first heard I was in menopause I, too, read everything I could on the Internet, and I did the same when I discovered I had a thyroid problem. But I don’t remember much anymore either,” I confess. “But,” I continue, pointing my index finger for emphasis, “what confuses me the most is that the doctor said it’s not uncommon for pregnant women to get thyroiditis. So this is a hormonal thing. But I wasn’t pregnant, and I began to wonder about the connection between going on and off the different formulations of HRT and my fluctuating hormones. I think someone ought to have told me or warned me about going on and off HRT so readily. Maybe that caused my thyroiditis or contributed to my condition.” I let out a sigh.

“I agree,” says Jane. “And if you look up antibodies or autoimmune disease on the Internet, you will discover that a lot of your autoimmune diseases, the majority of people affected by them are women.”

“I didn’t know that,” I state, startled.

“I can’t remember all of them but I know that mostly women get irritated bowel syndrome,” Jane explains.

“I wonder why doctors don’t warn us in advance of this stuff,” I ponder.

“I know, I know,” Jane concurs.

“Well, I’m happy you don’t have to take any medicine,” I state.

“Oh, for my MG? No, I’ve been on medicine since diagnosis. But we have gotten to a level that I can take it if I need it. I usually don’t need it. But yesterday I substituted at my son’s school and I probably should have taken a pill, because I came home and lay in bed for two hours while my son had quiet time, because my body was just worn out,” Jane explains.

“But once you sleep then you feel better?” I inquire.

“Exactly,” Jane agrees. “But sometimes I feel incredibly old when I go to bed at night and I’m taking all of these HRT formulas. I’m like, ‘Oh, my God, I’m 39 years old. Why do I have all of these drugs I’m taking?’”

Jane takes a long drink of coffee and fiddles with the wooden coffee stirrer.

I realize that I can’t identify with what she has gone through. My journey through menopause and my thyroid condition happened so much later in my life. She is such a young woman to have to deal with menopause and an illness too. It’s too much for me to process at the moment.

“You are so very young, Jane,” I state sympathetically.

“But, you know, you do what you have to do,” she interjects, matter-of-factly.

“Yeah, you have been through a lot,” I concur.

“It sounds like it, but there’s nothing that I don’t do,” she explains, nodding her head. “None of this has prohibited me from doing anything.”

“But you can’t have any more children,” I state.

“No, and that has been the major problem,” she confirms. “That was my major—I couldn’t have any more kids. And that was probably the number one psychological thing that was the worst, not being able to have another one. And it’s hard because my son is getting to the age where he is asking things like that. He will say, ‘So and so has a sister and brother,’ and ‘Why don’t I have a sister or brother?’ I knew these questions would come one day,” she states, crossing her arms in front of her. “I just didn’t know that they would come this soon.”

“Your child is so smart!” I state.

“Yes, he is,” she agrees, leaning forward with her elbows on the table. She smiles broadly.

“How do you feel about not being able to have another child?” I ask.

“Well, you try to look at the positive and thank God that you have one. But your feelings do get hurt every once in a while, even as strong as you want to be,” she explains.

“Did the doctor say you have no chance at all of getting pregnant? Can’t you take a shot to help your ovaries work? Can’t the doctors harvest some of your eggs?” I ask, not able to comprehend that she really can’t have any more children.

“My doctor did a very interesting exam. My doctor did an ultrasound and said, ‘Well, look, there are your ovaries right there—that one has no eggs in it and that one has maybe one or two, but that’s it,” Jane states.

“That’s it?” I ask.

“Yeah, but it was very interesting from a patient’s standpoint to be able to see that, because you initially think, ‘But what if this, but what if that, can we do this, can we do that?’ And you are like, ‘You have to be wrong.’ You go through that kind of thing mentally, and the doctor says, ‘No, no, see this? This is why you can’t have any more children.’”

“Yeah, I wouldn’t have believed the doctor at first either,” I confess.

We pause for a moment.

“You have told me a lot about yourself today, Jane. What else would you like to tell me or talk about today?” I ask.

“Well, I guess I told you what I had in my mind today. I don’t want to harp on the MG side of the world by any means. I know that, number one, that’s not what you are looking for and it really doesn’t affect my world. But I wanted to bring you up to speed on that so you would understand why I went into menopause at such a young age,” Jane explains.

“And I know you are on HRT, and I’m happy you are!” I exclaim.

“Yeah, and all of my doctors want me on HRT, mostly because of my age,” she explains.

“Does it bother you about all of the findings of the WHI? How are you feeling about all of that?” I ask.



“Initially, it did,” Jane explains, “I have to be honest. I did not call my doctor the day I read about the thing [WHI], because I knew they were getting thousands of phone calls. But I made an appointment to visit my OB-GYN at the time and my internist about a month later. I figured what are four weeks going to matter? I really wanted to be able to sit down and talk with both of the doctors instead of being passed through. And I knew they had to be getting a gazillion calls. But after sitting and talking with them and reading a little bit more about the research, it doesn’t. I mean there were lots of women, and the demographics showed other things, other health issues. Age factors and a lot of them were overweight. A lot of the women had health problems—heart problems, and blood pressure problems. So it wasn’t necessarily a good generalization, I don’t think.”

“Did you have the same OB-GYN at that time or were you seeing a different doctor?” I ask.

“I was seeing a different doctor at that time,” she explains.

“And that doctor also agreed that you should stay on the HRT?” I ask.

“Yes,” as a matter of fact, all of the doctors I’ve gone to say that the risks are far less than the positives that I am getting from being on the HRT. And it sure does make me a little bit more sane, and my family probably appreciates it too!” She laughs and runs her fingers through her long, blond hair. “Well,” she states, confidently, “I’m going to scoot so I can run a few fast errands before picking up my son at day care. Give me a call when you want to meet again.” Jane flashes me a big smile, says a final goodbye, and rushes off.

## Alexandria's Story

“Well, as I said on the phone the other night, I hope I have enough of my own information to make it worthwhile for you to have me in your project.” Alexandria shoots a furtive glance my way before turning her gaze back to the informed consent form in front of her. The crease between her wide-set eyes deepens. She stares at the form while she slowly smooths invisible creases out of the paper with a neatly manicured right hand.

“Absolutely!” I exclaim. “You will, Alexandria. You will! And I’m so happy to have you in my project.” Mustering as much enthusiasm as I can, hoping that my words will reassure her, I offer her a wide grin.

“You know, I just, how should I say this, I’ve read articles about HRT, but I certainly don’t remember everything that I’ve read.” She continues to smooth imaginary creases from the paper while allowing her light brown eyes to meet my gaze briefly. She is dressed in a smart-looking navy blue pants suit and matching blue pumps. Both hands are adorned with rings; her wedding ring on one hand and a beautiful diamond ring on her other hand. I can see that she has gotten all dolled up to meet with me today.

“That’s okay, Alexandria.” I enunciate my words slowly. “I’m interested in *your* ideas on menopause. I want to know what *you* think about menopause. It’s not necessary for *you* to know the latest information on HRT.” I place emphasis on the word “you” each time I say it, hoping this will serve to calm her anxiety. “We’re going to talk about

*you* and your experiences with menopause and hormone replacement therapy. I am interested in knowing about *you, Alexandria.*” I smile sweetly, looking directly into her eyes and wait for her response.

Her shoulders slump a little and she settles into her chair. She smiles shyly at me, allowing her eyes to meet mine for a few seconds longer, before she looks away again. “I used to talk with the gals I worked with and also talked a bit with the doctor’s staff from years ago, when I hadn’t even started my menopause. I talked with the receptionist and the nurses who were working in the front office. They would say, ‘you mean you haven’t started going through the change yet?’ I guess because I was older than they were, they were in their 40s, and I was already in my 50s, and I said, no, nothing is happening yet. And they went, ‘my God!’ And they couldn’t get over it. I don’t know why it was that way, but I guess I started going through the change a little bit later than normal.”

“We all start at different times,” I explain. “The average age of a woman going through menopause is around 50, but some women go through it earlier and some later. I have a woman in my group who stopped menstruating in her early 30s. So don’t worry about that.” I fan the air with my hand, as if my gesture will wave away her hesitation. “I’m really just asking for your opinion. And whatever it is, it’s okay with me!” I emphasize the last word, adding a playful tone to the conversation, smiling broadly at her.

“Well, the thing is, I’m kinda through it now,” she confesses.

“Me too!” I exclaim heartily. And I’m glad for it.”

“Well, you’re too young to be. I think you’re just too young to be,” she starts, surveying my face closely.

“Thank you, that’s very sweet of you to say that, but I’m 55 years old now.”

“No! You’re kidding. I would have never guessed.”

“Yes!” I state emphatically, proud of my age. “People don’t usually guess my age, but I’m getting old. When they do ask my age, I like to play around by telling people that I’m 92.” I giggle. “Age is not so important to me anymore. When I was younger, I moaned about turning 30 and I moaned when I turned 40. But the alternative to getting old is definitely not appealing to me! So, I’m okay with my age now.”

“I get some of that too,” she confides in a conspiratorial tone. She scoots her chair closer to me. “When I fell and broke my ankle this past August at the International Mall, I was laying in the gutter when two men helped me up. They called an ambulance service. And I guess the ambulance driver was asking them all sorts of questions. They said that a lady fell and that she needed an ambulance. ‘Well, how old of a woman is she?’ The driver asked. ‘She looks like she’s in her 50s.’ Alexandria throws her head back and lets out a howl. “Can you imagine that they thought I was so young? I’m 69 years old. Well, I momentarily forgot all about my pain and I laughed and laughed and said, ‘you know, that’s the best thing I’ve heard all day.’”

We chuckle and I can feel the mood suddenly lift. We both settle back into our chairs. We are sitting in the main conference room in the Department of Communication at the University of South Florida. This is my first visit with Alexandria.

“So, Alexandria, what I want to do today is to simply ask you to tell me a little bit about yourself. Tell me whatever you would like to tell me, okay?”

“Oh,” she starts. “Well, when we talked over the phone, we talked about our families. Do you want to know about my school years going back to my childhood or before school?” Her light brown eyes search my face for a reaction to her question.

“Absolutely!” I holler. “Tell me whatever you want to tell me about yourself.”

“Well, I learned to speak Greek before I learned to speak English. And as I got older, my brother and I had the Greek lessons and that was an important part of our life. If you saw the film *My Big Fat Greek Wedding*, where the kids had to go to Greek school, we really related to that, you know. But we had a Greek teacher that came to our home. A lot of the other kids we knew went to Greek School.” She explains.

“My cousins went to Greek school too.” I interject.

“That was an important thing in our life, when I was growing up,” she continues. “At the time we didn’t appreciate it because it was a time when we couldn’t go out to play. We had to stay in.” She confides.

*I am startled to hear her talk about her Greek lessons. I, too, took Greek lessons at home from a private tutor when I was younger, and felt the same way she did about the lessons. I wanted to go out and play, rather than stay in taking lessons from “Theo,” as I called the elderly man who came to the house once a week to give my siblings and me private lessons. My mind suddenly pulls up a memory of the long black chalkboard my father had made for us to use during our weekly lessons. A memory of my first Greek primer, with its bright red cover and picture of a young, Greek male pulls into focus momentarily. Alexandria is a good 15 years older than I am, and she was clearly raised more “Greek” than I was. Yet we share similar memories about growing up Greek in America.*

“We had a Greek teacher come to our house when I was in third or fourth grade, and I felt the same way you did!” I confide to her. “I too wanted to go out and play. But I also learned Italian when I was a little girl. I honored both sides of my ethnic heritage.”

“We were so deprived,” she chuckles.

“At least you remember your Greek. I don’t remember any of mine,” I interject, withholding my standard line that ‘the language is Greek to me now.’”

“Since I had to speak Greek to my mother, you know, I had no choice.” She explains. “And then I went through high school and I regret, I have a lot of regrets. I wish I could have done things differently. I would have worked harder, studied harder. When I was in high school, I just didn’t set any goals, because of the whole Greek thing. I was raised to believe that I had to get married and that my husband would take care of me. Well I was lucky. I married a very good man, a very good husband, whom I love and you know, he did take good care of us.”

“You had a good life. That’s nice.” I interject, soothingly.

“I had a good life,” she agrees. “But when I was 15 my mother had her first heart attack and that was very traumatic for me.”

“That must have been very difficult for you.” I state, sympathetically.

“She was about 50 when she had her first heart attack. She had high blood pressure, heart problems, and all of that. And the most difficult part about this experience was that I had no one to talk to about my fears.” Her voice cracks.

*I don’t know what to say to her, but I can clearly identify with her emotional reaction to talking about the events leading up to her mom’s death. I lost my dad when I was young too.*

“And, uh, finally, uh,” she sputters.

“Are you okay?” I ask, concerned at this turn of events.

“Yeah,” she confirms. “Yeah. I went to Waldon bookstore one day and found a book on women’s health written by a female doctor. I turned to a page and there was—I don’t know if you’ve ever read her book, but she has quotations from different people, from well-known people and people that I did not know of. And there was this little paragraph from this woman who was about 45 years old. And she said, ‘When I was a teenager, I watched my mother struggle with her heart problems,’ and I’m going like, ‘Holy Cow!’ and I’m reading this paragraph and it sounded just like me!” Alexandria shoots me a wide-eyed look. “I had to find a chair to sit down. I had to go all the way to the back of the bookstore to find a seat to read more, because this book told about myself. I read this book about 5 or 6 years ago, and all of this time I had those feelings inside of me, but they were suppressed. I didn’t want to bring them to the surface. But after reading that paragraph from that woman, and she said, ‘As I approach my mother’s age when she developed her problems, I have become very conscious of taking care of myself.’ And I thought, ‘Boy, if this isn’t me!’ My mother died when I was 22 years old. She died a week before my wedding. When she went into the hospital that last time, she told me she wasn’t coming home. And she made me promise to get married, no matter what happened. She said, ‘You’re going to get married.’ So, as it was, we got married, but my mom died a week before the wedding.”

The room goes silent.

*How brave I think Alexandria was to have moved on with her life and married while a shroud of death surrounded her. Look at how satisfied she is. She is so sweet,*

*and I am happy for her. Yet, I am also sad when I reflect upon the difficult times I endured during my father's illness and for some time after his death. I had a lot to deal with: a naïve, young woman barely out of her teens watching her whole world collapse around her while coping with a crushing burden of responsibility, managing an unfamiliar business in a dangerous area of town, alone, with no one to turn to for help—not even my boyfriend. I had met him and dated him during my first year at college. He had been in a fraternity and had given me his pin. That made us a serious couple. A small announcement of this event had been printed in the local school paper, and the women in my dorm threw me a small celebration. He and I were talking about marriage, but when my dad became sick I couldn't manage a relationship with him and my dad's business at the same time. Something had to give. Within a few months of taking over the day-to-day responsibility of the business, I lost my ability to communicate with him. I had become ensnared within a web of isolation, determination, pain, and danger and couldn't cut myself loose from its grip. I cut him loose instead.*

“I have one-two-three grandchildren and one great-grandson,” Alexandria continues, pulling me into the present moment. “And we've just all gone through life. Life has been good. Yes, we've have our ups and downs, and yes, I did have two heart attacks, but life has been good.” She smiles warmly at me. Her gaze is steady.

“You had two heart attacks? Alexandria, maybe you shouldn't be driving today.” I exclaim, worried that I may be asking too much of her. “Maybe I should come to see you at your home for our final interview. I don't want you to have to drive all the way to the university again.”



“Oh, gosh, please don’t say that. I mean, I’m not ready to be put on the shelf, you know.” Her eyes twinkle.

“Okay, okay, but promise me that you’ll talk with your husband and children and let them know about our interviews and see if it’s all right with them if you come to talk with me again.”

*I’m startled to hear that she has been so ill.*

“Oh, they’re not going to mind. They know their mom is going to do what she wants to do. And I’ve already told my husband I was coming here today. I told him I was meeting a nice lady at the University of South Florida today, but that I wasn’t looking for a job!” She laughs.

“All right, okay. I’m sorry.”

“But I did have a bypass.”

I let out a gasp.

“And they say I have congestive heart failure. So I’m on about 10 pills a day, including my insulin.”

I try to stifle another gasp. But the connection between the Women’s Health Initiative findings on HRT use and heart problems does not escape my attention.

“How long ago did you start taking HRT?” I inquire.

“Well, it’s hard to go back that many years. I was on one pill for a long time. My family doctor gave it to me. Perhaps it was the estrogen, and that kept my period going for a long time. It was really embarrassing before I started taking it. I was working and I was doing make-up and treatments on ladies faces and I would break out into a sweat. One day this lady says to me, ‘Are you having a flash?’ I said, ‘YES!’ And I started

having night sweats and everything, and not being able to sleep. My mom did talk to me about menopause. She told me that her periods just stopped one day. That was it. She didn't go through any hot flashes or night sweats like her friends were going through. And I told the doctor about that when I saw him, and he said, 'Well, let's hope you're as lucky as your mother was.'"

"Are you concerned that taking something might cause a problem for you?"

"Yeah, well, certainly taking hormone replacement therapy didn't help my heart because my first gynecologist says, 'this will be good for your heart, just in case, since your mother had problems. This will be good for you.' But come to find out from that article [on the findings of the Women's Health Initiative] that it might be a worrisome thing. At first they're telling you to take, take, take this, you've got to have this, and then the next thing you know, down the road a year later or so, they are saying don't do this or don't take that because ta-da, ta-da, ta-da, this is going to happen to you or you're going to get this if you take it. And it makes you feel like there's something wrong with the pharmaceutical industry. They seem to be rushing to judgment by saying 'Yes, HRT is okay,' and people are waiting for the miracle and the cure. I think it's too much government. There is too much government in it."

"So, how do you feel about HRT now? Are you still taking it?"

"I'm not taking it and won't if it's going to cause any other problems or future problems of cancer or whatever was mentioned."

"When did you stop taking HRT?"

"Shortly after the seminar at Crosstown Church. It put a scare in me. I called my doctor after the forum and told him what was discussed and what was happening, and he

said go ahead and gradually taper the medication off. Do it in a few weeks time, and you'll be okay. So I did, but I didn't taper off slowly. I went off quicker than he said. He told me to get something from the drugstore, one of the natural things. I can't remember what it is now, because I took it for a short time. I did get some hot flashes at first, but I didn't have terrible hot flashes and I wasn't pulling out my hair or anything like that. I was okay with it. I feel like I'm okay. I'm over it now.

“So now you're not taking anything?”

“No. And while I was taking the hormones, I was seeing the father of my current doctor. I'll refer to him as 'Senior.' I was seeing Senior, and I guess I can go ahead and say I was having a period at my age, and Senior kept me on the medicine and I had told him about my problem. Well, there came a time when Senior retired, and I had an option of where I wanted to go. I could go to his son or any other gynecologist in town. As soon as I visited the son, who was very nice, very personable, and very gentle I told him his dad had kept me on this stuff, and I've been getting periods. And I don't have to be having periods at my age.”

“How old were you at the time?”

“Oh, gosh, I've been going to the son for about 4 years now, so I was about 65. Can you imagine - getting your period at 65! Like clockwork, every month. But anyways, I told him I don't need to be having this, and he gave me the other pill, so that I would not have a period. So I was on estrogen and progesterone.”

“At first you were on one pill, right?”

“Yeah, I was on the one first with Senior, and then his son put me on the other.”

“What was the other?” I ask, confused as to what she was taking.

“I think it was estrogen at first, the first one.”

“Estrogen. Is that what the father put you on, and then the son put you on progesterone?” I ask.

“Yeah. So then I was taking two, I think. Yeah, I would take one for so many days, and then I’d take another pill.”

“Did you still have a period then?”

“Eventually, I didn’t have one. And to this day I thank God, I don’t have my period anymore.”

Still confused over what she was taking, I try again to clarify what she was on. “Do you remember what you were taking?”

“Prempro, I think. Prempro is the one that stopped my period, right? It stopped the periods.”

“What color was the pill?” I ask, hoping this might help me clarify which medication she had been taking.

“See, I’m not good at this right now, because my memory fails me as to which one I was taking. But I was taking one for so many days and I’d stop. And then after a while I was okay. I think I was on estrogen with Senior and then the son added another pill that made me stop bleeding.”

“The reason I’m so curious as to what you were taking when you were seeing Senior is because I know you have your uterus.”

“Yeah,” she confirms.

“So I don’t think Senior would have given you just estrogen, because research shows that you should not take estrogen alone if you have your uterus.

“I’m sorry, I’m not so clear on this. My memory isn’t good on this stuff,” she apologizes.

“That’s okay. It’s all right. If you can, ask your doctor, but if not, that’s okay,” I explain. “So, how do you feel?”

“I feel like a normal person now, and I’m glad to be off HRT forever.

\* \* \* \* \*

Alexandria and I meet many months later for our final interview at my new apartment in New Tampa. She is smartly dressed again but in a more casual, brightly colored summer pants outfit, and her short, brown hair is neatly combed into an old-fashioned bob. She looks cute. She has brought me several presents—she baked me telopetia, a cheese filled filo-type pie, and she has brought me a copy of the cookbook she and her church published.

We spend a few moments discussing Greek recipes. She tells me that she has several recipes in the book. One of them is for Greek-style potatoes and another is for telopetia. I confess my love for skordialia, a garlic spread that leaves every pore in your body reeking of garlic for several days. We laugh. She signs my cookbook.

“Speaking of cookbooks—this is something I wrote and entered into a contest.” She pulls several documents from her purse. “I entered the Betty Crocker contest when they wanted to change the image of her. Remember when she used to have blond hair and blue eyes for years? But now there are more Italian people, more Latinos, and Orientals and Greeks in America. We are a true melting pot with all the different ethnicities in America. So I entered a Betty Crocker contest. You had to write something

about yourself and send a picture, and they were going to select a new image for Betty Crocker. So I wrote them a story about my life.”

She sniffles for a moment, but regains her composure quickly. “I didn’t win, but they sent me a certificate that I have saved all of these years.”

She shows me the certificate and then unfolds a letter and begins to read me her entrance letter that is titled, “The Best of Both Worlds.” She explains that the title represents her ability to blend her Greek recipes that she learned from her mom with American cooking that she learned using her Betty Crocker cookbook. As I listen to her read her story about cooking for a growing family, it occurs to me that Alexandria has been a delight to talk with. She seems to represent the best of both worlds for me, too, a little from my Greek past and, by participating in this project, also a little of my future.

“As our children grew, our menus became more diversified. Hamburger Helper was a big hit, and Bisquick, with its easy recipes conveniently printed on the back of the box was always a staple in my pantry.” She continues to read from her letter. I sit back and listen, with a smile on my face.

## Ruby's Story

It's the early part of August, a brutally hot time of the year in Tampa. It's so hot outside that the air conditioner in my new apartment can't seem to cool sufficiently to keep me comfortable. Being menopausal doesn't help matters. I moved into this apartment in the New Tampa area a few weeks ago and the cooling problem is causing me to wonder if I made a mistake selecting a third floor apartment with vaulted ceilings. But, nevertheless, I am excited to be able to hold my final interviews in my new place. I can't wait to talk with my participants. It's been about 5 months since we completed the focus group processes, so I'm looking forward to catching up on their lives. Ruby has arranged to stop by after work tonight for her final interview. She is the first of the group to hold her final interview. In anticipation of her arrival, I arrange a spread of food, mainly teas and pastries, on a small table that I have set up in the living room near the French door leading to my screened-in balcony. I decided we should talk in this room, because it's filled with bright light and offers a panoramic view of the complex. While I rush back and forth from the kitchen to the small table, I think back to my first interview with Ruby. We met at her office, and although the preliminary interview went as well as could be expected in such a formal, stiff environment, there were too many distractions. We sat with her large wooden desk between us, her phone rang several times, and a man popped his head into the doorway on occasion to ask her a question or two. She told me that payroll week is always hectic, and that she had to be available to "wipe butts around

here.” I still can’t shake that image. I am hoping our talk today will reap the rewards of the private and comfortable environment of my apartment.

I arrange packets of Earl Gray tea, my favorite, in a semi-circle on the white linen tablecloth and below them I lay out foiled packets of other teas in smaller arcs; English Breakfast, Lemon Lift, Raspberry Royale, Orange Spice, Peppermint, and Green Tea. While I work, I feel familiar blasts of heat surge through my body at regular intervals, even though the thermostat is set at 65 degrees. I try my best to ignore the heat. I place the two large cinnamon and apple buns I purchased at Panera’s Restaurant earlier today on top of a white doily. The pastries look inviting to me, slathered in a rich-looking dark sauce, and covered in sugarcoated pecans. I make a mental note to stay away from the pastries when Ruby arrives, as I’m battling a weight problem. Next to the pastries, I arrange Pepperidge Farm butter cookies onto a serving plate, and, on my way back to the kitchen I notice that my bare feet are leaving indents in the freshly vacuumed carpet.

*Oh, my God!* I think to myself. *I can see the outline of my toes.*

The carpet looks as if the mythical Big-Foot monster has paid me a visit. I make one last trip to the table carrying sliced cantaloupe, skim milk, cream, and packets of Splenda before running the vacuum over the size 9 ½ impressions in the rug.

The phone rings.

“Linda?”

I recognize her voice. I can hear the hum of traffic in the background.

“I’ve just come to the end of Highwoods Preserve, but I can’t find your apartment complex.” Ruby yells, to compensate for the background din.



“You went too far,” I explain. “Turn around and come back a few blocks. I’ll come down to meet you at the gate. It will be easier.” I grab my sandals and rush over to the entrance gate. She pulls up in a shiny, red BMW, and I slide into the cool, tan leather seat on the passenger side. Ruby looks marvelous for a woman of 60. She is thin and fit, and looks like she might be in her early 50s. Dressed in a navy-blue pants outfit, with low pumps, gold earrings and a slim gold bracelet, she looks pulled-together and professional. She has a high-school education, and I like the fact that she worked her way up through the ranks of her company. She has done well for herself, in my opinion. She used to be an avid roller-blader until a year ago, when she fell and damaged her knee. But even though she has sworn off roller-blades, she has managed to maintain her slim figure. I wonder if her husband of 6 months has contributed to her youthful outlook on life. He is 8 years her junior. Is she a prototype of a postmodern postmenopausal woman? I wonder.

“Is it cold in here, Ruby,” I inquire, when we enter the apartment. I can’t seem to feel the air. “I’m getting major hot flashes and the air doesn’t seem to be helping.” I let out a sigh.

“It’s comfortable,” she responds. “It’s probably not as cold as my place, and if I were working, you know, moving around, it might feel warm for me too.”

“I think that air isn’t working properly,” I grumble. “I’m going to call the maintenance manager tomorrow and have him take a look at the unit. I’m boiling.”

Without skipping a beat, I ask her, “What do you think of my hair?”

“I love it!”

“Do you like the color?” I ask, feeling uncomfortable with the shade.

“Do you happen to have any idea how beautiful your skin is?” Ruby marvels. Taking a step closer, she peers intently at my skin. Her eyes move slowly over the surface of my face. She is surveying my face with the same scrutiny I use when picking lint off my slacks with my aging eyes.

“No! I think I look bad,” I howl, blushing. I take a step backward. Her directness has startled me.

“No, no, you have beautiful skin and it is just so clear and, and it’s gorgeous. And your hair looks great!” she exclaims.

“Do you like my color?” I ask again, looking for confirmation.

“He did it lighter?” She squints, gazing at the top of my freshly sheared blondish-red head of hair.

“Yeah, lighter, but he didn’t cover the gray. See!” I let out a sigh. Running my fingers through my hair, I grab a large patch of hair on the right side of my head and pull it back, holding it tightly, in order to give her a chance to get a good look at the shock of unruly, pure white hair growing in on that side of my head.

“Okay, now I can see it,” she confesses, “but it looks great! He didn’t leave it on long enough or something?” she inquires.

“No, and I didn’t want any red in it,” I complain. “I would rather have it darker or lighter than too red, because this red doesn’t look good with my skin tone. He put in as much ash color as he could, because that color is closer to my natural blond color, but it didn’t cover the gray well at all. I sigh again. “He managed to cover some of it, but most of the gray didn’t cover. It’s resistant to color,” I confide to her, repeating what my hair colorist told me earlier today.

I seem to have become more concerned about my looks since I have entered menopause, especially since my hair has grayed during the last few years. And the hair colorists I have seen can't seem to replicate my natural, ash-blonde hair. No one gets the color right. I think that it's a farce to believe that synthetic color can match the beauty and shine of one's natural color. And lately I've noticed that the texture of my hair has changed, along with the texture of my skin. Both have become dry and scaly. I've developed skin-tags on my arms, a definite sign of old age.

"I like the cut," she interrupts. "The cut is great!" she declares, trying to smooth over my exasperation.

"Well, it's all right, but I feel so uncomfortable. I'm so fat! I have to lose weight and then maybe I'll feel better. I am too big," I confess. Pulling my arms wide apart to emphasize bigness, I roll my eyes and frown. "I am carrying too much weight on my frame, and have had major problems with my weight since entering menopause. I have gained weight and can't seem to lose it. And I tire out so easily these days. Sometimes I'm just too tired to work out."

"No, no your hair looks great!" she reassures me again, deflecting my comments about my largeness.

"I like the way my hairdresser does mine, but when I fix it, everybody asks why I can't fix it the way he does!" Ruby explains. "He makes the ends spiky, but I can never do that."

"Your hair is low maintenance, isn't it?" I ask.

“I have it cut every four weeks, and every third cut I have a perm. And when I first have the perm, when I wash it in the mornings, I have to pull it out with the blow dryer. There is nothing low maintenance about this!” Ruby exclaims.

“Oh, it looks so nice.” I say, complimenting her on her nicely textured, shock of thick brown, short hair.

“But when I have a perm, I have to, eh—say, do you have a burner on? I smell something burning.”

“Oh! No!” I exclaim, running into the kitchen. “I forgot! I left the burner on high, but luckily hadn’t put a pan on. Thanks!” I reply sheepishly.

*I’ve noticed that I seem to be more careless and forgetful these days, especially since I have been going through menopause. But I have always been somewhat forgetful. Like the time I decided to sit down and write a letter to a friend while waiting for the bathtub to fill, and the next thing I knew hot water was spilling all over the floor. Then there was the time I decided to boil water for tea, and walked away from the stove to work while the water came to a boil. The next thing I heard was a loud popping sound, as the bottom of my stainless steel pan separated from the base, ruined by the heat. I think that one way that I experience menopause is with a shorter attention span. I seem to be more spaced-out than usual since I’ve entered menopause. I wonder if this is just my way of entering into the realm of old age.*

I show her around the apartment and then I begin to arrange the microphone near the table in the living room.

“The chairs are kind of small,” I say apologetically. “You can tell I’m a student.”

I am referring to the two miniature black folding chairs that I bought for \$8 each, when I first moved to Tampa 5 years ago.

“That’s fine. I think they are darling. Your whole place is so homey,” she says, graciously.

“I brought you a few snacks, so that you won’t hurt your appetite,” I explain looking at the huge spread of fruit and pastries I had laid out for her. “We could cut the pastries in half, so you won’t have to worry about your weight,” I suggest. “Place your teabag in your cup, and pour hot water from the glass pot onto it,” I coach her.

“I wasn’t sure what the glass thing on the stove was for.” She confides, referring to my glass teapot.

“It’s really meant to steep loose tea, but I’m using it today to store our hot water.”

We start munching.

“How is Anna doing? Does she seem to be coping with things all right, or have you not had time to talk with her yet?” Ruby asks.

She is asking about one of the member of our Sunday focus group who had recently gone through a divorce and was in the process of selling her home.

“I haven’t really talked to anyone. I called all of you about the same time to make plans for our final interview. She is due to come out in a few weeks, so I’ll find out then.

“And by the way, I have not made any changes since our focus group meetings,” she explains.

“You were going to see a doctor, right?” I ask.

“Yes, and she didn’t tell me to make any changes. I told her that there was some discussion [in the news reports] about taking nothing. You know, I’ve been on Prempro since I was 50 and was just at the point where I was beginning to cut back when I saw an advertisement for the seminar on menopause and very shortly afterwards the articles came out about how bad HRT was for you. Prempro was probably the worst one and frankly all of my friends were taking something else. By that time, I figured I had been on HRT for 7 years, so if they were going to kill me, maybe I would have been dead, so I kept taking them. I won’t say I didn’t worry about it, but I didn’t immediately make a change because I wasn’t going to a doctor on a regular basis at that point. I told the doctor that I had cut my pills in half. In other words, I’m taking one every other day. She was basically totally non-committal. And as far as the testing that went on [WHI] and everybody getting hyper about it, I don’t think she was overenthusiastic about the testing results. She said it was very few people [who showed symptoms] and they were bigger people that probably might have had more of that [heart problems] in their family.

“Yes, I heard that too,” I say. “Do you want some Splenda?”

“I don’t take sugar; I don’t do sweets in my tea. But I eat plenty of sweets.”

“I read that the women were heavy in that study too,” I explain.

“My bigger problem with this is what are they taking now? And are they going to come up with a study in 5 years to say that everything women are taking now is not good for them because it is all new stuff? That is what happened to us after 5 or 10 years of taking the other (Prempro). I don’t know how long it has been out,” she concludes.

“I don’t know what women are taking now,” I confess.

“I wish I had written it down, because I have one or two friends who have told me about it. In fact I have two of them who said their doctors gave them the same identical thing, but I can’t remember what it was. I wish I had written it down. And that would be my other concern; the fact that I have been taking it now for about 10 years. That, I think, was the other thing that my doctor agreed with. If I were going to have a problem, it probably would have happened already.

“Ruby, since you brought up the focus groups, I wonder, what did you think about me participating? You know, I’m also going through menopause, and I talked a lot during our sessions. What did you think of that?” I ask.

“Oh, I enjoyed it. I felt you were a part of the group. It was supposed to happen that way. I guess if you stop and thought about it, if it was some 25-year old talking to us, that didn’t have a clue as to what we were going through, I don’t think it would have meant as much to us. I think the mere fact that you are going through it probably was more beneficial to the group. And if it helped you, then good, or didn’t help you, but just gave you a little more insight, but no, I can’t imagine doing that same thing with somebody who wouldn’t have a clue as to what we were talking about. It seemed to work very well.”

“That’s a good point.” I interject, steering our conversation back to doctors. “My other group talked about doctors. And one went to a young doctor who had no children, was probably 28-years old, and right out of med school. She wasn’t happy because she said how could anyone understand what it is like to go through menopause when she is so young?”

“Well, I have always felt that way about my gynecologist,” Ruby responds, “and I felt that same way about my therapist, which I had a chance to use while I was going through my divorce. There was no way I would have gone to a male [therapist] to talk about my divorce after 38 years of marriage. I was devastated. But I couldn’t imagine talking about this stuff to men either. They [males] can’t relate to each other, how could they possibly relate to me? So, I couldn’t possibly go to a male doctor. I don’t think they could relate to my issues.”

I fiddle with the microphone and the backup tape recorder that I have placed on the window ledge near our table to ensure that both are working properly.

“So, you are still taking Prempro, every other day?” I continue.

“Yep, and I’m on blood pressure medicine, which I had also cut back to every other day,” she confides. “I have two pills. There is a water pill along with the Antenol, and I take one on one day, one the next day.”

“And your doctor said it was okay to do this?” I inquire, worried that she might hurt herself.

“Yes, and maybe, I don’t know, I guess I’m one of those people who will get to a point in time when things kinda settle down and I’ll try it for a week without taking either one of those to see if I can still maintain –”

I interrupt her. “You’re talking about your heart medicine? I don’t think you should tinker with your medicine.”

“It’s really blood pressure medicine.” She corrects me.



“I wouldn’t play around with your medicine,” I caution her. “If you were to have a heart attack, that would be it. I read that women stand a lower chance of making it through their first heart attack.”

“I always thought the blood pressure had been brought on by the accident and that when things settled down, it would go away. But it didn’t. Once I stopped cold turkey, my pressure went up. Once I tried taking St. John’s Wart and immediately got spots flying around and got dizzy within a day of taking that pill. I took it the next day with the same effect. It didn’t last all day, but within an hour or two of taking the pill, I got dizzy. So I stopped taking it. I talked to somebody at a General Nutrition Center health store about a year ago about a diet pill. They had a three-pill-a day routine that was supposed to be natural, and the clerk asked me if I had high blood pressure. And when I told him I did, he said I couldn’t take that, and he gave me something else. I’m not exactly sure what was in there, but there are some things in some of that supposedly natural stuff that is not good for you. See, I don’t buy the ‘if it’s natural it’s good for you’ thing. That’s baloney.”

“How do you feel?” I inquire, referring to her every-other-day Prempro routine.

“Ninety percent of the time I feel just fantastic. I do take a vitamin daily. But I am pretty active. I got a little bit concerned because I was going home and sitting down at nights. But once in a while you need to do that. I have a tendency to need to go, to run. And one of the things I have done is start a dance class. For years I took line-dancing classes. But that was before my divorce. I would line dance two or three hours a week.”

“When you hurt your knee, did you stop for a while?” I ask.

“No, I stopped when I went through my divorce. It takes a ton of concentration for me to dance, and when I went through my divorce, I couldn’t concentrate.”

We turn our attention to her pictures. She has brought me pictures of her mom, her husband, her two daughters, their husbands, her three grandchildren, her daughter’s dog, and pictures of her women’s sorority group.

“Ruby, we have to talk about this picture,” I say, pulling one out of the pile.

“Well, obviously, he is a good sport!”

“This is your husband?” I ask, looking at a picture of a man sitting on a couch wearing a woman’s housedress, smiling directly into the camera.

“I don’t know why I made him do that. Yes I do!” she corrects. “I wanted to wash whatever he was wearing and I threw that dress at him and said, ‘you will give me your clothes to wash. And he did. Of course it is big and full, otherwise it would never go around his rather supple body. Like I said, he is a good sport. Most men wouldn’t let you remove their clothes so you could wash them right there.”

I laugh. “He is a good sport.”

“Hey, Ruby,” I start, “Did you ever get that vaginal cream Stephanie talked about in our focus groups?”

“No, not the cream, I got the suppository. And the thing about it is my sex life isn’t extremely active. It is not dead, but it is not two and three times a week.

“I remember that the suppository she brought to the focus group looked pretty big—was it?” I ask.

“No, it was a tiny pill that goes onto the tip of an applicator. But the problem is to remember to use it.”

“It’s estrogen, isn’t it?” I ask. “And the purpose of it is to plump up your vagina, right? I know that I mentioned this problem during our focus groups, but I’m worried about the elasticity of my vagina. Since I’ve gone through menopause, I’m afraid that my vagina is shrinking, and I worry about vaginal dryness too. I think you have to use it or lose it. My doctor gave me a prescription for an estrogen ring, but I couldn’t fill the prescription because the cost of it was over one hundred and thirty dollars. Too much for my meager budget.”

“I think a month’s supply of this suppository would be worth \$30, basically what the Prempro costs me on my health insurance program.

“Ruby, I’m surprised that you need a suppository for vaginal dryness. You have been taking HRT and having sex on a regular basis. I would think that all of these things would serve to protect your vagina.” I state, confused.

“Well, to be real honest with you, my husband is huge. Not long, but he is HUGE. Since I didn’t have a problem having sex with my first husband, my ex, I’m thinking my husband’s size is part of the problem. Sometimes I wonder if big maybe isn’t better. Isn’t that what everybody says, bigger is better, but sometimes it might not be.” Ruby says, reflectively.

“I once dated a man who was huge, and I found having sex with him was not comfortable,” I confide.

“Well, this is what I maintain: Because I’m not using it every day, I think my vagina is shrinking, he is huge, and then you’ve got the dryness problem. So I have all three of those things working against me. Now, I’ll be the first to admit that once everything is lubricated and moving along, then it’s great,” Ruby confides.

“I wonder what would happen if you did take the suppository. It’s made to be used daily, right?” I ask.

“Yeah, I probably would put it in during the night, specifically, so that I was getting the full benefit of it while I was lying down. Although I never noticed anything drop out when I used it in the past.”

“But what do the instructions say,” I ask. “Are you supposed to put it in every day or just as needed, before you have sex? Maybe it is to be used as needed.”

“I think it is,” she concludes.

“I still don’t know why you need to use anything, because you have been on estrogen, even though you are through menopause. I’m not on estrogen, and through menopause, so I understand why I need something,” I explain.

“I’m thinking my HRT wasn’t a high dose. I don’t know much about it, but I’m not doing it every day, because it does hurt to have sex,” Ruby says.

“I remember you told us that you made a big sacrifice coming to our Sunday focus group sessions because that was your day to have whoopee,” I explain. “So, why don’t you use a suppository Thursday, Friday, and Saturday, and see if it helps you with any discomfort you might feel?”

“But even when I did use the suppository, when I was doing that, I still used the K-Y Jelly on him as well as myself. You know, the thought just occurred to me that maybe someone will invent a suppository that you use literally as you are having sex, something that can get inside of you as your partner is thrusting inside and out. But, my husband and I are at a disadvantage too, because he is having a hard time getting an erection, and he has for years before I got with him. He uses a shot,” Ruby explains.

“You mean to get an erection?” I ask.

“Yes,” Ruby confirms.

“Does he take Viagra?” I ask.

“Well, I don’t know exactly what is in the shot. I think the shot is for people who are a little bit further gone than somebody that takes Viagra.”

“Oh, really?” I ask. “Then, he has to plan sex?”

“Yes, so between me having to worry about what I have to worry about and him having to worry about it, you talk about expensive and a pain in the you-know-what!” she says, sounding exasperated.

“It takes a huge coordination,” I conclude.

“Yes,” says Ruby.

“Does he have to go to the doctor to get a shot?” I ask.

“No, no, no. He gives it to himself, but the prescription, the little bottle is worth \$80. I’m trying to think how much you get out of it. That’s another thing that you have to figure out, what’s not too much. Because too much and you are miserable, he is miserable for a good half a day,” confides Ruby.

“Having an erection all of that time!” I state, startled.

“Yes, he will. And I remember one time when we first got together and it happened and I thought, ‘this is the nuttiest thing I have ever seen.’”

We both laugh.

“Poor guy, was walking around with an erection,” I laugh.

“Yeah, right, and it hurts. So you have to figure out what really works,” says Ruby.

“Does he give himself a shot in the penis?” I ask.

“Yes, oh yes,” she responds.

“That must hurt,” I conclude.

“I’m trying to think of what problem he was having, but he finally went back to the doctor with it, and the doctor said that you don’t give yourself a shot in the same place all of the time.”

We both laugh.

“There is another thing I forgot to talk about. If you give yourself a shot in the same spot all of the time, when he would do it, it was starting to turn,” says Ruby.

“You mean his penis was turning?” I ask, startled.

“Yes, the doctor then gave him some medicine that would be for something like bursitis. I think that was the kind of medicine.

“You mean your husband had bursitis of the penis?” I chuckle.

“Yeah, we live and learn,” she laughs. “But we have to make a concerted effort to have sex, it isn’t all just ‘spur-of-the-moment, I am totally in love with you, let’s have sex for five minutes’ kind of thing. It’s like you have to shower, get excited, and you know, like I said, we had to work on how it works. If he takes that shot and jumps right back in bed, sometimes it doesn’t work. So it’s easier, we figured out if he takes the shot and then takes a shower, giving it time to work. And then it’s gonna last a while. He had been doing this for 10 years and the thing about it is you don’t use it, you lose it, well, if you can believe what he said about being a bachelor since he was 25 years old, he said he was using it a bunch. A bunch! I think you would call him a ho if he were a girl. So, why this happened to him, I don’t know. I suppose one good thing to come out of this is

that he makes very regular trips to see his urologist. I think he is more regular going to see his urologist than he is going to the dentist,” Ruby explains, reflectively.

We talk on about other aches and pains and other topics until finally I ask her if there is anything else she would like to tell me about her life in menopause.

“Life is good. Menopause just isn’t a big part of it. It doesn’t bother me. I got on track with whatever I did when I turned 50, and 10 years later I’m not unhappy with it. So I continue to take it. But I modified it to suit me. But life is good. It’s been a long time coming.”

### Malika's Story

“There is this lady, a blond lady, driving a corvette going real fast. She gets stopped by a blond policewoman, and the policewoman says, ‘I need to see your driver’s license, you were driving too fast.’ The driver looks in her purse and says, ‘what does a license look like?’ And the policewoman says, ‘it’s that thing that has your face on it, your picture. You know, you look at it and there is your face.’ So the driver says, ‘okay, I’ll look for it.’ She reaches into her purse and sees her compact. She opens it up and begins to fix her makeup when all of a sudden it dawns on her, ‘Oh, there is my face.’ So she hands the compact to the policewoman and the police lady looks in the compact, rolls her eyes and says, ‘Oh, for God’s sake! Why didn’t you tell me you were a policewoman?’”

The women in the room howl with laughter.

“I’m blond, so I can tell this joke,” Malika yells.

We are meeting in the Interaction Lab in the Department of Communication at the University of South Florida. We usually meet in the departmental conference room, but the faculty are holding a meeting in that room today. Bunny, one of my participants, is running late, and I am worried that she might accidentally barge into the faculty meeting, so I have left my other two participants in the lab with the tape recorder on while I run out to post a note on the conference door directing Bunny to the proper room.

I re-enter the lab, breathless.



“Linda,” Malika exclaims excitedly, “I put a joke on the recorder while you were gone!” She giggles, her light blue eyes sparkling.

“Okay,” I say between gulps of air, “I look forward to hearing it when I transcribe the tape. But what were you saying about hormones and diabetes before I left the room?”

“I was saying that they are all tied in together, and that women who have diabetes tend to get a big stomach. And doctors are tying diabetes into starvation because when you have type 2 diabetes, as I have, you’re hungry all of the time. And the reason why we gain weight is because we’re hungry. We don’t get enough insulin and our body tells our brain to eat, eat, and eat. And that’s why we’re always eating. And you know, the hormones are raging and all messed up because you’re in menopause and they’re shutting down and so—”

“And that affects your insulin, too?” I interrupt.

“Yeah,” confirms Malika.

“Where did you get all of this information?” I ask.

“That chat group. The people were talking about this,” says Malika.

“On-line?” I inquire.

“Yeah, but it’s not really a chat group, it’s a list-serve, and they give you all of these sites on-line to go to. It just started about two weeks ago, and there are already too many people on it, because everybody is so excited. The thing is everybody is telling their stories right now, and I’m finding out that some people can eat potatoes and some people can’t. Some people will eat a baked potato and their sugar will go through the roof. And other people like me, I can eat a potato and it will make me go to sleep at night. But if I have it in the day, it doesn’t bother me.” She diverts her attention to the

packet of Splenda she has just retrieved from the spread of food that I arranged at the head of the conference table before our meeting. “Oh, no! I meant to get cream but I grabbed a packet of sugar instead.” Her brow creases. She lets out a big sigh and gingerly lifts herself up out of her chair, using the ornately decorated brown and silver walking cane she has brought with her today to steady her body. Slowly, she makes her way to the head of the table to retrieve cream for her coffee. When Malika returns to her seat with the cream, she and Alexandria arrange their chairs around the far corner of the large, square conference table. I situate myself across from them.

“Uh, this room is too large for us,” I groan. “I bought a new back-up tape recorder. As you all know, I’m a bit of a klutz when it comes to recording our conversations.” We all laugh, knowingly, while I show off the pop-up microphone feature of the miniature tape recorder that I recently purchased.

“Oh, is that cool,” coos Malika, studying the microphone closer.

“Yeah, it is neat,” I agree. I scoot the back-up recorder closer to me so that I’ll have an easier time reaching for it when it’s time to change the tape. “Vina is probably not joining us today—right, Malika?” I inquire.

“I don’t think so,” explains Malika.

“No problem,” I state. “It’s rather standard to have people drop out of research projects. That happens when you are working with live subjects.”

“Yeah, she started a job today,” Malika explains, matter-of-factly.

Malika and Vina are close friends and drove together to our first focus group meeting. But I couldn’t locate Vina when I called her home to confirm this one. I suspect that she didn’t want to attend any more meetings, because she wasn’t invested in

the process. I recall that she didn't have too much to say during our first session. But I don't confide my thoughts to the women. Instead, I fiddle with the conference microphone that I have attached to my large, main tape recorder, to ensure everything is properly secured. I press the rewind button on the recorder and play back a portion of our conversation to make sure the table microphone is picking up our voices.

"When you first interviewed me, you said I had a soft voice," announces Alexandria, watching me move through my microphone ritual.

"Yes, but your voice is picking up beautifully today," I conclude, after hearing a strong and steady stream of voices booming through the microphone on playback. "I hope I can situate this table microphone closer to you two," I mumble, stretching my right arm as far as I can across the wide expanse that separates me from the two women. I struggle to give the microphone one final shove with the tips of my fingers, trying to push it further to the center of the table, but the microphone doesn't budge.

"Let me help you," laughs Malika. Using the handle of her walking cane, she quickly scoots the table microphone closer to her side of the table.

"Thanks!" I exclaim. "Now I can face all of you and won't have to worry about our voices not recording or carrying well in this large room." I smile appreciatively. Malika nods her head in confirmation. Because she also attends my Sunday focus group sessions, she knows that I'm technically challenged. There have been times when I have forgotten to start the recorder after I have changed the tape.

"I'm really happy both of you could join me today," I exclaim, smiling broadly. "I originally scheduled six women into this session, but three of them cancelled. Bunny

should be here any minute, but I think we should get started without her. She can join our conversation when she arrives.”

“Anyway,” starts Malika, “as I was saying, doctors are tying big stomachs to the fact that you’re a diabetic.”

“Uh huh,” I state, wondering if what she is saying is true.

“That’s strange,” states Alexandria.

“Yeah, I thought it was interesting too,” confides Malika. “When I was younger, I preferred eating fruits and vegetables, but lately I want carbs. I want potatoes, potatoes, potatoes!” She exclaims.

“I crave sugar these days,” I interject. “I never had much of a problem watching what I ate or watching my weight, and for most of my adult life I have been a size 10 to 12. And when my 12s would become tight on me or if I started to spill into a size 14, then I would simply go on a diet and lose the few pounds necessary in order to fit back into my 12s. But since I’ve been going through menopause, I seem to crave sweets, and I have gained a huge amount of weight. Maybe I gained weight because of the stress of being in a Ph.D. program.” I reflect on this idea for a moment. “It’s possible I gained so much weight because my thyroid closed down while I’ve been in my Ph.D. program. But in either case, I seem to crave sugar.”

“So you don’t want salt, you want the sweetness of sugar?” Malika asks.

“Yeah. When I was much younger my father went into renal failure. He was a kidney patient, on dialysis. Since he couldn’t have salt, I also took table salt out of my diet. I did that in the late 1960s, so I guess I get enough salt from the food I eat, even

though I don't eat processed foods. But my diet has gotten very poor since I've been in the Ph.D. program.”

“Where do you find iodine then? How does it fit into your diet?” asks Malika.

“Yeah, well, I know we need iodine, but I guess I'm getting enough. I don't usually salt my food, but when I came down to Tampa I changed my diet. First of all I would come home late, around 9:30 or 10:00, from my evening classes. I would be hungry and very tired, so I started making quick meals late at night. I would boil up a batch of potatoes because they were so quick to make. I would slice the potatoes really thin so they would cook quickly, and then I would mash them and slather on butter and salt. So I did start to eat table salt once I moved to Tampa.”

“I'm allergic to it,” states Malika. “If I have salt, my face will blow up like a balloon.” She laughs.

“I use sea salt,” interjects Alexandria. “Since my husband and I have heart conditions, we're both recovering heart patients, we try to stay away from too much salt. I do use a little sea salt when I'm cooking, but I never add salt at the table,” she confides.

The door to the lab swings open, and Bunnie bursts into the room carrying a large blue thermos and a beige wicker basket covered in a lace cloth napkin.

“Hi everybody!” she smiles at the women seated at the far end of the room, sets the basket and thermos down at the head of the table, and quickly begins to arrange small, bite-sized Persian sweets onto a plate. I recognize the sweets as the same kind I had when I visited her home for our first interview. They are made from a finely ground paste of chick peas or pistachio nuts mixed with honey, and are very good. She bustles around the table, pouring each of us a steaming cup of Persian tea from the thermos. She

has brought along pictures of her dining room table, arranged for their Persian New Year and proudly shows them to us. Malika has also brought pictures of herself when she was younger, and passes them around the table.

“Malika, you are gorgeous in that picture,” I exclaim.

“I know it,” she admits, letting out a sigh “and we just tell everyone that underneath our scarves we are all Miss America!” She smiles broadly.

She is referring to the lacy hejab she has tightly wrapped around her head to cover her blond hair. And in the tradition of her Muslim faith, she has also covered her body in cloth from head to toe. Today she is wearing a periwinkle blue long-sleeved blouse with matching pants, and suede-looking black flat shoes.

“Malika, when you hear that word ‘menopause’ what comes to mind?” I ask.

“I see my mother. The house is freezing cold and she’s beet red. Beet red. Not sweating, but just very red, sitting in front of the television knitting, watching a program, rocking, with a fan running on her.

“And do you see that happening to you?” I ask, wondering how she feels about being so close to menopause.

“I’m waiting for that to happen,” she giggles. “Anything else, to me isn’t menopause. That’s why I have been blowing off my recent symptoms. I thought if you didn’t have the house set at 60 with an oscillating fan going, then you’re not in menopause.”

“What symptoms are you getting?” I ask.

“I’m hot flashing, and I guess I have been right along, but I just thought it was from my high blood pressure. And I get the weepies, and this has been going on for about two years periodically. I thought I had PMS, or I thought I was just depressed.”

“What are you doing about it?” I ask.

“Absolutely nothing. But people tell me that I’m a hypochondriac or something like that,” Malika confides.

“Who tells you that?” I ask, surprised at her comment, even though I know that it’s not unusual to hear that women are not taken seriously.

“All the males in my family. And the females in my family are much older than me, and they seem to have forgotten that they went through this. And I remember my mother getting hot flashes so badly that for almost a two-year period she didn’t go out of the house. She wouldn’t leave the house. She had that air conditioner cranked down low and she would sit in front of it.”

“She sounds like me!” I laugh. I keep the air in my apartment at 65, sometimes lower when I have a really intense hot flash.

“It used to be freezing in our house,” Malika continues. “My mom would have that air conditioner turned down and it was freezing, just freezing, in our house. It was awful. And she would sit in front of the television crocheting. I think Watergate was going on at the time. My mom used to say she was crocheting Watergate afghans!”

Malika chuckles at the memory.

“Do you do that now?” I ask.

“No.”

“What do you do? Do you need to have the air on too?” I ask.

“I wear very few clothes in the house. Maybe I’ll wear a tank top dress.”

“Oh, I do something similar,” I confess. “I’ll wear shorts.”

“And flip-flops,” she continues. “And I’ll wear my hair up in a ponytail so it’s off my neck. That’s why I don’t have short hair. It’s cooler to have long hair because then I can put it up on top of my head. And I have either the air or the heat on, because I like the house at a certain temperature.”

“So, you’re not taking anything?” I ask.

“No, but I’m telling you I’m going to go and ask for some of these, what were they called? Somebody talked about a vial that you insert into your vagina. I wrote it down.” Malika rummages through her purse looking for the small, spiral notebook that she has been carrying to our meetings.

“It’s a suppository,” I interject.

“Yeah, a suppository,” she confirms. “I’m going to ask my doctor about it because I do have dryness, and—”

“You mean vaginal dryness, right?” I interrupt.

“Yeah, vaginal dryness,” she agrees.

“Stephanie, from our Sunday focus groups, was talking about that suppository,” I state, remembering the conversation we had in our last Sunday group about vaginal dryness.

“Yes, and normally I wouldn’t talk about this in front of people because I’m really shy. But the other ladies [in the other focus group] did talk about this, so I decided it was okay to talk about this.”



“That’s okay, Malika,” I state, “if it bothers you, it’s okay if you don’t want to talk about this.”

“It helps you open up,” interjects Alexandria.

“It does, it does,” confirms Malika.

“Malika, how do you feel about going through menopause?” I ask.

“Well, a lot of the ladies in the other group said that they were going off or whatever, she explains.

“But what do you think, Malika?” I inquire again.

“I am going to check into it. I am getting ready to call my doctor and ask. Because I was on the patch, and I would fly to the states to see my doctor every three months, you see.”

“Oh, you are talking about when you lived overseas, right?” I ask.

“Yes. And one day I came in to renew my prescription and one of the things I was going to renew was my estradiol patch, but the doctor refused. She said, ‘We’re not doing that anymore. I’m taking all of my patients off of it. And that was just it. But I’m telling you as soon as she took me off of it my skin started drying up terribly. Within two weeks I noticed a lot of wrinkles around my eyes. My skin started to look like lizard skin, you know, very dry. And I had to start using K-Y Jelly,” she explains.

“Is your vagina dry?” I ask. “And is that why you need a vaginal lubricant?”

“Yes, and I haven’t had any [sex] for awhile, but I want to get ready because I’m healthy and you know my husband will be coming back this summer, and I want to have some fun. I also want to soften my skin. I find that now that I’m healthy, after all of my surgeries and my liver is growing back, that I seem to be improving. One of the things I

want to improve are my hormone levels. I also, you know, the pheromones, I also felt like when I was on HRT that I seemed to be exuding pheromones, I guess, for being a vibrant woman or something. You're going to laugh, but one of the changes I've noticed about menopause right now, now that I'm an overweight, elderly woman—."

"Oh, you're still young," I interrupt her. "You're only 46 years old."

"Yeah, but, I look older and because I've been sick, people don't tend to look at me, I mean younger men don't look at me. But before, when I was younger, I could tell the difference. I could walk down the street and walk by men and they would look at me, and I could feel a vibe and they could feel a vibe coming from me. It was a pheromone. I know it was," she confides.

"And how has that changed?" I ask.

"There's nothing. I am not interested in my husband."

"So, you mean your sex drive has changed?" I ask.

"It's gone. Not there. Not interested."

"Alexandria, you were talking about the same issue earlier. I wonder if maybe this issue isn't related to medicine alone. Maybe it's partly from menopause, I don't know." I reflect on the conversations I had with other participants about their lack of sex drive.

"I couldn't care less either," interjects Bunnie.

"And if I recall our conversation, Bunnie, you said your sex drive changed before you went on the Progesterone cream, right?" I ask.

"Even now!" she exclaims. "I think it has to do with my mental state. I mean I'm not interested. It's nice, sometimes. Great! It's wonderful to share affection and

tenderness and all of that with my husband. But most of the time I'm so tired because I have so many different things I need to do. So, that's the last thing I want to bother about, you know. At the end of the day I just want to rest."

"I noticed that my sex drive has changed too," I remark. "It did decrease, but it seemed to come back once I started HRT," I explain, uncertain if there might be a connection between the two events.

"Exactly," agrees Bunnie.

"One day I realized that I just didn't feel as horny as I used to," I explain. "That's how I experienced it. You know how you always feel your body."

"Yeah," agrees Bunnie.

The women laugh.

"Yeah, me too!" exclaims Malika.

"And it dawned on me that when I went on HRT I began to feel revved up again," I confide, feeling confirmed as a result of the women's level of agreement on this issue.

"Yeah, I agree," says Bunnie.

"But Bunnie, you have young children. You're running all of the time," I conclude, placing her lack of libido into a different category than mine.

"Yes, my husband calls me an old lady!" she confesses.

"Your husband calls you that!" I exclaim. "And you're so young, you're in your thirties."

"I remember being in my thirties," interjects Alexandria.

"Yeah, me too. A long time ago!" I chuckle, thinking back to the pretty, young woman I used to be at that age.

The ladies laugh in agreement.

“So tell me again, Malika, how you feel about HRT?” I ask.

“Well, I’m confused right now. Now, let’s see. Is the vaginal pill, the suppository, is that also an HRT?” She asks.

“That’s estrogen,” I explain.

“That’s estrogen,” she repeats. “That’s the safe thing to take, right? The thing that’s not safe is the Premarin, the pills you can take, right?” She looks in my direction, waiting for confirmation.

“Well, I don’t know what is safe,” I state. “I’m not a doctor.”

“I agree with you,” concurs Bunnie, nodding her head in my direction.

“Doctors don’t know,” says Malika. “But I’m confused because my doctor pulled me off the patch. I don’t know what the doctors do now, but we used to put the patch on one ovary in the front, and then the next month put it on the other ovary.”

“Are you talking about the pellets you mentioned to me in an earlier conversation?” I ask.

“No. No. The pellets were put on the side. As a matter of fact this whole section here is filled with scar tissue on both sides of my hips.” She points to her side.”

“Wow!” I exclaim. “And the doctor really sliced into your skin to put those pellets inside of you?” I ask.

“Yes, about a fourth of an inch wide and deep and he would put in a tiny pellet,” confirms Malika.

“That’s crazy!” howls Bunnie, surprised to hear this information.

“The pellets were the size of a Saccharin tablet,” Malika continues.

“And then you went onto the patch?” I ask. “What was the name of the patch?”

“Estradiol. I would put one on my hip.”

“It was like a sticker?” asks Bunnie.

“Yeah, it was clear, and you peeled off a clear thing that was sticky and you put it on. I had a little problem because the adhesive would cause my skin to turn pink.”

Malika explains. “And that is what I used for years and years.”

“I don’t trust anything that is attached to my body,” explains Bunnie. “Because if it doesn’t work, I’m stuck with it. I feel very uncomfortable about that. But the cream is working for me now. I do not trust artificial things. But at the same time, how do I know that the cream is really safe. There isn’t any long-term research done.”

“But you feel good?” I ask.

“I feel great. If it wasn’t for the cream I couldn’t do the things I do,” Bunnie explains.

“I felt better on the pellets,” Malika interjects. And when they first switched me over to the patch the decrease in estrogen was so much, I started crying and crying and asking him to please put me back on the pellets. But he said, ‘I am not going to put you back on the pellets.’ I even called up the company in California to find out where I could go to another doctor to get them. They told me to write a letter to Washington, because they’re pulling our grant money and not letting us continue our research on the pellets. And I have all of that information. I can pull that out, if you need it for your records,” explains Malika.

“No, that’s not necessary, Malika,” I said. “Alexandria, what do you think about all of this?” I ask, thinking that Alexandria has been quite silent for a while.

“Well, I’m learning, I’m learning. I feel like I don’t have much to contribute to our conversation,” she confides.

“Not true, Alexandria!” I state, hoping to encourage her. “You do contribute to our conversation.”

“Yeah,” confirms Malika.

“Absolutely,” I state.

“But when Malika talked about those pellets, well, I have never heard about them before,” Alexandria confides. “That’s a new one to me.”

“Neither have I,” I explain.

“It’s all so foreign to me,” she continues.

“Be glad you missed it,” says Malika.

“I’m glad I did.” She states.

“Alexandria, tell me how your life changed now that you’re through menopause,” I ask.

“Well, it seems like everything is going along pretty well. I’m 69 years old, and now that I’m through menopause, I personally feel better. I’m not worried about those things,” she explains.

“What do you mean by those things,” I ask.

“I mean the change of life and menopause. That’s all behind me now. I went through that stage, and now it’s all behind me. But unfortunately, other health problems have developed that may have nothing to do with menopause. I’m always aware of how important it is to take care of yourself, but I cheat.”

“Did you ever smoke cigarettes?” asks Malika.

“Yes, but I quit going on 18 years,” Alexandria explains.

“What were you going to say about the changes you see in yourself now that you’re post-menopausal?” I ask. “In fact, if you wanted to advise these two younger women on some of the changes they might expect to experience, what would you tell them?” I ask.

“Knowing what I have learned in the recent past and in the present time, I would say certainly be very careful of what you’re going to take and what the doctor’s going to prescribe. And research it! This is making me think, believe it or not, of all of the heart medications, the beta-blockers, and the low blood pressure and the Coumidin, a blood thinner, that I’ve taken. I’m just now thinking that maybe I should see a holistic doctor. I’m taking a lot of stuff, a lot of medication. And that worries me. It gives me more concern. I read something recently, it had something to do with medication. Let’s see, I’m not too clear on this, but it had something to do with heart medication and something to do with women’s health issues and menopause. I saw something that clashed, but I can’t seem to remember what it was. I’ll have to go back and read about it.”

“So, was it something you saw in an article on the Women’s Health Initiative that made you think about some of the medicines you’re taking,” I ask, wondering if this was the connection she was trying to make.

“Yeah, but I read so many different things and my eyes have been bothering me lately,” she confides.

“That’s all right, Alexandria,” I state. “If you were to advise these young women, what would you say to them?”

“I would say to think twice about whatever the doctor says. They say, ‘Oh, we have something new and it’s this and it’s that.’ Look what they said about Premarin and estrogen and look what’s happened. Now we know that it’s not the best thing for us. And that horse urine business that was mentioned earlier brought to mind a woman that I knew who was large-framed. She was a lovely woman inside and out. She was always concerned about her weight. And she went to some doctor and he gave her something that had horse’s urine in it. I think her husband was after her about her weight. And so she was on this pill or medication that had horse’s urine in it, and one day she was on the phone and she dropped dead.”

We gasp.

“And everybody was saying that it was that horse urine medication, that pill that she was on, that caused this to happen. So, there again was something the doctor prescribed and they probably didn’t know what the outcome was going to be. But what were the statistics? How long had they studied it before they came up with this pill?”

“It’s crazy,” interjects Bunnie.

“I say to forget it,” continues Alexandria.

“Since I started showing symptoms, being perimenopausal, I started going in another direction, an alternative direction. I’ve discovered many things,” confides Bunnie. “The major picture that I see is with our bodies is that it’s not just about menopause, it’s not a one-time thing, and then another thing. It’s all related. The menopause thing is related to, for example, the hormones affect the adrenals and the adrenals affect the thyroid. The thyroid affects everything else. So, it’s all related. And it’s not just our physical body, it’s our mental body, it’s our spiritual body too. Our



spiritual body gives strength to our mental and our physical body. Our body is like a pharmacy. If we try to find a way to balance our body in all aspects of our lives, then we have a better chance of having better health. If we educate ourselves in nutrition, in exercise, in different alternatives for taking care of our health, like acupuncture or energy work, or different and new medications that might save our lives, because all medications are not bad, then we can create a balance in our lives. I'm just beginning to go through pre-menopause. I'm looking at everybody else down the road and I can see what everybody else is going through. And I think that the advice that Alexandria gave is very true and significant. I think that is something to live by. And I think that if we don't look just one way but look at all the other ways, then we have a better chance of making better decisions. In my case, I have many years to look forward to. Not only that, I'm thinking way down the road, because my husband is quite a bit older than I am. And he's twice my size. He has big, thick bones. I will have to take care of him when he gets older. I'll be in the prime of my life. And I'm going to have two kids, maybe three to take care of along with a business to look after. So, what am I going to do? I'm going to try to take good care of myself. What do these changes in my body mean? Well, they trigger thoughts, questions about my life. What are we going to do? I was very sad when I started noticing that I was having symptoms of menopause. But I expected it. It was simple logic because I got my period when I was young, so it makes sense that I would go through menopause while I was young.

“Malika, has your life view changed as a result of being menopausal?” I ask.

“Yes, it's starting. But it's a shock. I remember when I was a teenager the ladies in my neighborhood would complain about bloating and hot flashes.”

“These were older women?” I ask.

“Yes, and they always complained about salt. And they would take some kind of pill,” explains Malika.

“Probably a diuretic,” interjects Bunnie. “You might as well drink pineapple juice, it’s the perfect diuretic.”

“A lot of my friends are still having children,” explains Malika. “They’re in their 40s, but I can’t have any children. So when I go to parties and there are all of these people with children, the kids start to get on my nerves. But my own grandchildren live out-of-state, and I don’t see them. So, I’m starting to gravitate to even older women, women without children. And that’s a big change for me. It’s only been in the last six months that I have realized that I can no longer have children. That’s it. We’ve been trying for 10 years, and it’s not going to happen. I am not going to have the little girl that I have always wanted.”

“I lost a little girl,” confides Alexandria in a soft voice, “in the eighth month. So I can relate to you, Malika.”

“My heart, my heart.” Malika begins to sob softly. Tears spill down her cheeks.

“But you will find some kind of peace with yourself on this,” Alexandria coos softly, stroking Malika’s back to comfort her.

“I know,” Malika says between sobs. “I know.”

“It’s okay, it’s okay,” says Alexandria gently, “we have to let some of these emotions out sometimes. And we all go through them.” She continues to stroke Malika’s back.

“It’s okay to cry, Malika,” I say softly.

“Yeah, we all feel pain sometimes. And we hurt,” explains Alexandria.

“Malika,” I say gently, “can you tell us what you are thinking about?”

“For the daughter I lost, and for the ones I’ll never have. For the ones I could have had had I stopped to smell the roses.” Her shoulders heave up and down, and she lets out a big sigh, wiping her eyes with a napkin. “You are so busy with your career right now, Linda. Don’t push too hard. Don’t forget to worry as much about your personal life. Because otherwise, Linda, you’re going to end up sitting there saying, ‘whoa, here I am by myself.’”

The room is silent except for Malika’s gentle, sporadic sobs.

## CHAPTER FOUR

### ANALYSIS OF THE WOMEN'S STORIES

When I was a young woman, I heard the term “menopause” bantered around in family conversations. It was used to refer loosely to a woman’s “change-of-life.” But I never knew exactly what “change-of-life” meant, except that it was when women stopped menstruating. The women in my study also talked about “change” in terms of bodies that no longer menstruated. In addition to this, though, they used the term “change” when discussing a myriad of personal issues related to children, their bodies, aging, sex, and men. They also talked about changing when they discussed symptoms of menopause, finding a doctor, and making decisions related to their future health as a result of the findings of the Women’s Health Initiative (WHI). And so this chapter is about change—from an applied perspective in terms of how the women coped with and made sense of menopause, but also from a theoretical perspective on the underpinnings of the women’s sensemaking on menopause. I begin my analysis by tracing the women’s journeys through menopause, using information taken from the transcripts of our interviews and focus group discussions, from the time they first realized they were approaching menopause through to their current sensemaking on menopause and the WHI. Blended within the women’s journeys through menopause is my commentary on their sensemaking in terms of Emily Martin’s medical metaphors and Michel Foucault’s ideas on discursive formations. Then I discuss the Women’s Health Initiative and change, and

finally, I draw some conclusions and suggestions for the future regarding women's framing and sensemaking of their bodies-in-menopause.

### The Journey

Some of the women didn't realize they were approaching menopause. They felt they had no apparent outward symptoms of menopause, but were told to begin treatment with hormone replacement therapy (HRT) by their physicians. Anna's experience is a good example of this: "I don't think that I had even recognized it until I was at one of my yearly check-ups. My doctor said to me, 'you ought to be on estrogen.' I suppose I was in my late forties and my periods had already started to change a bit. They had not stopped, but were just changing." Ruby had a similar discussion with her doctor: "I had been taking [birth control] pills for 30 years and at that point in time the doctor said, 'okay, we'll stop them.' I wasn't a smoker so that wasn't an issue, but she says, 'let's stop them.' I'm trying to think exactly what made me, other than my age, and that's probably what it was for her, and she said, 'well let's just stop it and go on hormones.' Ruby's doctor told her she ought to stay on HRT for the rest of her life, which, she explains, "was kind of a shock to me. I said, 'you have to do that?' Her theory was that it just keeps you more female, more soft, and helps you stay lubricated."

Bunnie, in contrast to Anna and Ruby, went to see her doctor complaining of a variety of symptoms. She was tired all of the time, felt sad and would cry for no reason. She used to awaken in the middle of the night soaked, and wasn't sleeping well. She also had hot flashes and vaginal dryness. When she visited her doctor, she said, "he looked at my body and said, 'you're keeping weight in the middle section of your body, because your estrogen is too big.' I was high on estrogen—dominant. I was estrogen dominant."

Her doctor gave her a saliva test to confirm his diagnosis, and then suggested she use a natural progesterone cream to help alleviate her symptoms.

Listening to the women's stories about how they came to realize their bodies were approaching menopause reminds me of Emily Martin's (2001) discussion of medical metaphors that circulate in our society about women's bodies. Martin suggests that women's bodies have been constructed within prevailing, dominant cultural ideologies that serve to inform the way physicians and women think and talk about a woman's body. Martin says that even though traditionally we think of science and medicine as operating outside cultural assumptions, because their focus is an "objective" search for the "truth" about nature, she postulates that science and medicine are a hegemonic system operating within our society, supportive of the interests of the dominant class. When women internalize these assumptions, the assumptions become their common-sense ways of making sense of their bodies. The metaphor that appears to ground the women's stories is the *body-as-a-signal-response system*. According to Martin, this metaphor is the most prevalent model found in current medical texts, so it is the metaphor that most physicians use to frame their understanding of women's bodies. Martin provides examples of this metaphor, such as, "the hypothalamus receives signals from almost all possible sources in the nervous system" and "as a result of strong stimulation of FSH, a number of follicles respond with growth" (Martin, 2001, p. 40). But, Martin explains, the brain-hormone-ovary signal-response system is usually described as a hierarchical information-transmitting communication system with directions coming from one dominant element, the hypothalamus. This hierarchical communication system is similar to the dominant form of organization in our society. She says that once we have this hierarchical,

information-transmitting imagery in place, then any failure of the signal-response hierarchical structure for reproduction, such as menopause, forces us to associate negative imagery with the cause of the breakdown of the system of authority. Therefore, even though we have negative stereotypes of aging women in our society, this hierarchical model helps to account for some of the negative imagery associated with menopause in our society. She explains that within this model, “the cause of ovarian ‘decline’ is the ‘decreasing ability of the aging ovaries to respond to pituitary gonadotropins.’ At every point in the system, functions ‘fail’ and falter. Follicles ‘fail to muster the strength’ to reach ovulation” (Martin, 2001, p. 42).

And so, with menopause, we have a language and a frame of reference used by physicians that describes a women’s body as a system in decline. Anna and Ruby, without experiencing any apparent symptoms, were told by their physicians to start taking HRT because they were anticipating that the women’s bodies were starting to fail. Bunny’s physician, who also framed her body in terms of the signal-response system metaphor, described her body as beginning to fail because it had begun to lose its balance of estrogen and progesterone production.

When the women I interviewed spoke about HRT, I also heard implicit within their talk the *body-as-a-signal-response* metaphor, in that the women envisioned their bodies starting to fail and in a state of decline. For example, Anna wondered aloud, “are we silly for not taking [HRT]? Are we going to end up all wrinkly if we do live to be 90? But don’t we have medication for our bones and better studies to assess whether we have osteoporosis. If we are smart, we are keeping track of our heart and we won’t get heart disease.” Malika spoke of bodily improvements she hoped to make with HRT. “One of

the things I want to improve are my hormone levels. I also, you know, the pheromones, I also felt like when I was on HRT that I seemed to be exuding pheromones, I guess for being a vibrant woman or something.” And Bunnie spoke about the benefits of taking the progesterone cream that she purchases at her local health food store. She explained, “based on the imbalance that you have with your hormones [the doctor] will determine how much you need of the cream. In my case, I used one full pump in the morning and one full pump at night. But since I now feel balanced, I am using only one full pump of progesterone cream at night. . . .” Underlying Anna’s comments is the notion of her body in decline, with her concern over developing wrinkles, a traditional symptom of an aging body, or developing osteoporosis or heart disease as a result of the absence of HRT. Malika wanted to balance her hormone levels so that she could retain the pheromones she felt she exuded when her estrogen production was in balance. Bunnie also spoke in terms of her body out of balance. She reasoned that by adding progesterone cream daily, she would be able to restore her hormonal balance.

Some of the women were concerned about the health of their vaginas and spoke in terms of their bodies failing to produce enough estrogen to ensure a healthy vagina. For example, the women had the following conversation:

Linda: I’m not taking HRT anymore, but I know that estrogen keeps your vagina supple, and that’s another thing that worries me. I’m scared that my vagina might shrivel up, because I’m not sexually active now and I think that you have to use it or lose it!

Stephanie: You would feel very uncomfortable if it dried up. I had a friend who was about 71 or 72. Her vagina was like wood. She went in for an exam and the



doctor couldn't get the speculum in, they couldn't get anything in there, so she had to soften up, because they couldn't get in there to do what they had to do.

Ruby: I take Prempro, and I am dry, very, very, dry. So I can't imagine what I would be without my HRT. . . . My doctor says it keeps me lubricated.

Stephanie: It does, that is what I have heard.

Ruby: But I use it and it doesn't do any good. I say it doesn't. I mean it is still very painful . . . I went for a long time not doing it. And the first time I thought I was just gonna die. It was no fun.

Linda: Even though you were on estrogen?

Stephanie: But the thing is, you may still need the Astroglide or whatever. I think it's a both thing. Because, we don't have all of these eggs that are wanting sperm, and we're not like trying to pull them in there. It's a different thing. But the doctor told me about Astroglide and that's why I got it. Otherwise, I would be using K-Y. It's superior.

Linda: I'm confused, and I certainly don't know personally what to do, so I'm doing nothing now. And in the long term I don't know what that will do to my body or my bones, and I am very concerned about my vagina for the future. I'm telling you, one day I'm going to have sex again!

Stephanie: You have hope! You can have sex by yourself, you know.

Malika: We should all pitch in and buy her a good old fashioned you-know-what. You know, an electric little thing!

Stephanie framed her ideas within the body-as-signal-response system metaphor, suggesting that her ovaries were no longer getting a signal to attract sperm. Her ovaries

were, therefore, failing to do their job of attracting sperm. Ruby and Linda also spoke in terms of failure, but they spoke of *bodies-as-failed-production* in that their bodies were not producing enough estrogen to protect their vaginas from drying up without outside assistance, either from a penis, a vaginal lubricant, or a vibrator.

When I first learned from the health center doctor that I was in menopause, he told me that my body was “estrogen-deficient,” and that I needed to take HRT in order to control my symptoms. I remember feeling betrayed by my body, mystified as to how it could be that I now had to ingest a pill for the rest of my life in order to replenish something that my body had stopped producing as a result of a natural process. I had tried my best to take good care of my body over the years, but felt as if my efforts had been in vain.

Martin (2001) argues that because the central purpose of a woman’s body has been constructed in medical terms as a baby-producing vessel, then the monthly menstruation is seen as a failed attempt for our body to produce a baby. Menstruation is a failed production. Along this same reasoning then, menopause is the ultimate failure of a woman’s body.

The women framed their bodies in terms of this failed production metaphor when they talked about menopause and children. For example, Malika lamented her sense of loss over not being able to have more children as a result of menopause. She broke down and sobbed while explaining her situation:

A lot of my friends are still having children. They’re in their 40s, but I can’t have any children. So when I go to parties and there are all of these people with children, the kids start to get on my nerves. But my own grandchildren live out-

of-state, and I don't see them. So, I'm starting to gravitate to even older women, women without children. It's only been in the last six months that I have realized that I can no longer have children. That's it. We've been trying for 10 years, and it's not going to happen. I am not going to have the little girl that I have always wanted.

Jane, who at the age of 39 found herself suddenly thrown into menopause due to the onset of an autoimmune disease, gave a positive spin to her sense of loss:

I couldn't have any more kids. And that was probably the number one psychological thing that was the worst, not being able to have another one. And it's hard because my son is getting to the age where he is asking things like that. He will say, 'so and so has a sister and brother,' and 'Why don't I have a sister or brother?' I knew these questions would come one day. I just didn't know that they would come this soon . . . Well, you try to look at the positive and thank God that you have one. But your feelings do get hurt every once in a while, even as strong as you want to be.

Anna, on the other hand, who identified herself as first and foremost a mom, explained her loss in terms of the empty nest syndrome, as her children prepared to leave home:

I think of myself as a mother. I guess that is because being a mom has taken up so much of my life. I'm at the end of that now, because my kids are able to take care of themselves now. One of my kids is 25 and the other is 19. My youngest is ready to go off to college next year. So she will still be a part of my life for a while. My son is off in Orlando, and I miss him, but we see him quite a bit, so that is working out. . . . Of course my husband and I were going through

difficulties then too, so, ah, I was just—probably menopause was also a part of it. I was very weepy when my son left. I was busy working, but the menopause, the emotions and all of that may have been a part of it too.

Stephanie was typical of the older, single woman who decided not to have children earlier in her life, either for financial, work, or relationship reasons, and now finds that it's too late. She explained, "I always felt that I would have to be able to afford a nanny and that my kids would have to go to private school. And if I couldn't do that then I just didn't want to have children." When I asked Stephanie if she felt like she couldn't afford to have children, she responded with a resounding, "Oh, yeah. Absolutely!" As she and I were childless, older, single women, I shared my personal observations with her:

Isn't that interesting! I too have always felt that I couldn't afford to bring a child into the world because I was too poor. But then you look around and see other people having children and living paycheck to paycheck, and they seem to have managed. So, did you ever wonder about that contradiction? That you thought, that I thought how could I bring a child into this world when I'm not financially set?"

Stephanie discussed her vision of the right way to bring up a child:

Well, for me it would definitely be having a partner to share the responsibilities, and I've never thought of any other kind of relationship besides being in a married relationship. I don't necessarily have to be married to have children, but I never thought I would be in an unmarried relationship with children. That's not me.

All of the women in the study took some form of HRT, either in synthetic form or in a form considered natural, in an attempt to manage or eliminate their symptoms of menopause. Most of the women tried more than one type of HRT formula. For example, Stephanie's gynecologist prescribed Ortho-Prefest, a low dose hormone, for her intractable vulva itching. Anna took Prempro for a few years, switched to a two-pill regime of estrogen and Prometrium and then to the Vivelle-dot. When she began to feel weepy, her physician suggested that she begin taking an antidepressant. Jane and Ruby used Prempro. But when Jane's uncomfortable symptoms continued, she was given Cenestin, in addition to a compounded HRT formula plus an antidepressant. Alexandria was also on a two-pill HRT regime. And I tried one HRT formula after the other, looking for something to ease my severe hot flashes and weepiness. I tried Prempro, Premarin with Provera, Activella, and Mircette. With each of these medications, I developed neurological symptoms, and each was unsuccessful in easing my symptoms. I was eventually placed on the Climara patch plus Prometrium. This combination HRT helped to ease my symptoms, but did not eliminate them. The gynecologist I was seeing prescribed different dosages of Climara, so that I could regulate my dosage according to my symptoms. For a while my bathroom cabinet resembled a pharmacy, as the shelves were stacked high with dosages of Climara ranging from .025 mg. to 1.00 mg. in addition to boxed samples of an antidepressant prescribed for my weepiness and samples of Ambien, a sleep aid. I never took the antidepressant or the sleep aid, but used the various dosages of Climara, depending on the severity of my symptoms.

When thinking about the vast number of hormone replacement and other menopausal medications that were prescribed to the women, I am surprised at how easy it

has become to think of a woman's body as something to manipulate and control. Martin (2001) suggests a reason for the propensity for us to try to control our bodies. She explains that in our modern society, it is possible for a woman to remain on some form of hormone therapy from the time she begins menstruating until she completes menopause. For example, menstruating women as young as 14 begin taking birth control pills, and potentially may stay on them until they are ready for menopause, except for respites for baby-producing. As a result, some women may never experience their adult bodies in their natural form, without exogenous hormones. And they may never experience their bodies other than as something to manipulate and control. This idea of the manipulation and control of a woman's body may inform the way a woman frames her own thinking on her body in general, and more specifically on HRT and menopause. For example, if a woman becomes accustomed to treating her body as something to manipulate and control, similar to the way we control a machine, this might set the stage for her to think and talk about her body as an object, or a vessel to top-off or fill-up with fluids such as estrogen and progesterone.

Our propensity to manipulate and control our bodies also brings to mind Martin's discussion of the *body-as-machine* metaphor. This metaphor was used first in the seventeenth and eighteenth centuries in France to discuss the birthing process, and continues to frame medical practices today. A woman's uterus is described as a mechanical pump able to expel a fetus. Male doctors, playing the roles of mechanics or technicians, acted upon women's bodies, as machines, in order to fix them. Over time, men's hands, and man-made mechanical tools, such as forceps and slings, came to replace the hands of midwives in removing babies from women's uteruses. With this

body-as-machine metaphor, the uterus was considered to act and contract independently of a woman's will.

Jane, talking in terms of the body-as-a-machine metaphor, tried to determine how much estrogen she needed to use in order "top off" her levels to keep her body functioning at its peak shape. She asked her doctors to take a baseline test of her hormone levels, but had a difficult time finding a doctor to help her. She explains:

You don't have a baseline on what to go off of. . . . All of the doctors I've been seeing, they'll put you on something, but they don't know what your level is. No one ever wants to test me. And they all tell me, "well we don't know what your levels were before." And I'm like, "well isn't there some baseline?" I mean, when I first got diagnosed, and basically now, when you look at me on an ultrasound, I have no eggs in my ovaries. They're totally gone.

The body-as-machine metaphor also has broader implications for women's identities. Martin (2001, pp. 19-20) suggests that when we assume that our bodies can be fixed by mechanical manipulation, it encourages us to ignore other aspects of our selves, such as our relationships with others and our emotions. It also encourages women to see themselves as fragmented body parts rather than as whole people. Our cultural acceptance of the body-as-machine metaphor encourages us to continue to impose emerging technologies upon women's bodies, blending our desire to dominate and control the environment and women through their bodies. Even though Martin believes that this metaphor alone no longer dominates medical practices, it certainly was evident

in the stories my participants' told of the dizzying array of HRT treatments they used in an attempt to control their symptoms of menopause.<sup>5</sup>

The women also talked about their menopausal symptoms as though their symptoms were acting upon their bodies, independent of any other factor, such as their stress levels or feelings, and without accounting for personal situations. They appeared to view their bodies as fragmented and separate from their selves, as if they had no agency over their situations. The body-as-machine metaphor encourages this type of thinking in terms of women's bodies. For example, when discussing her menopausal symptoms, Alexandria stated:

It was really embarrassing before I started taking it. I was working and I was doing make-up and treatments on ladies faces and I would break out into a sweat. One day this lady says to me, "Are you having a flash?" I said, "YES!" And I started having night sweats and everything, and not being able to sleep.

When discussing her weight problem, Stephanie stated, "I have learned that hormones keep you kind of fat and I have totally lost my, eh, not ambition, but my desire to exercise. I got into this thing with a personal trainer, but then all of a sudden I did not want to do it anymore. It kind of coincided with menopause." And Jane described her mood swings while she was on Prempro as follows: "I remember one day driving on

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<sup>5</sup> I attended several seminars on menopause in the Tampa Bay in the summer of 2002, and heard doctors refer to the bodies of menopausal women in ways that reminded me of the body-as-machine metaphor. For example, while listening to physicians lecture on natural HRT, I heard physicians talk a dizzying language of hormonal deficiencies and replenishment strategies. They explained the symptoms of estrogen deficiencies, such as hot flashes, night sweats, vaginal dryness, foggy thinking; symptoms of estrogen dominance, such as mood swings, weight gain, fibrocystic breasts, water retention, low thyroid symptoms; symptoms of androgen deficiency, such as low libido, depression, heart palpitations, bone loss, and on and on, discussing progesterone dominance and deficiencies, and low and high adrenal cortisol levels. The women's bodies were discussed as though they were car engines in need of lubrication, to be topped-off with fluids, such as estrogen, progesterone, and testosterone, in order to stay in tip-top, working condition.



Gandy Boulevard and at one red light I just wanted to kill the driver in front of me. And at the next red light, I was almost in tears. I'm just not that kind of person and had never experienced PMS to a large degree. And so I called the doctor and went, 'What have you people done to me—I'm psycho!'"

Each of the women took either a synthetic or natural form of HRT on the recommendation of their physicians. All but one of the women agreed to take HRT without complaint. Anna was unique in that she resisted her doctor's suggestion that she start taking HRT. She explained:

I'm breezing along, and it's about 1999, I guess I was around 50 and my doctor said, "How are your periods?" "Well, they are a little sporadic," I said. I was always kind of irregular. She said, "Well, you really should start taking estrogen now." And I went, "Nah, nah, nah, nah—I don't need that. I'm not ready for that." But she said, "Oh, you should because you really need it because you are a thin, Caucasian woman. You need to protect your bones, and you have heart disease in your family, you have colon cancer in your family. You need to take it for those reasons." So, I went home and read everything I could, and finally [after numerous conversations with my doctor] I agreed to take it. Never was happy about it.

Even though some of the women changed HRT formulas as time went on, they worked with their physicians when making the change from one formula to another. Two of Martin's (2001) medical metaphors mentioned earlier, the body-as-machine and the body-as-a-signal-response-system, could explain the women's compliance with their doctor's suggestions that they take HRT, in light of the fact that the women framed their

menopausal bodies in terms of an “estrogen-deficiency” model. But something else may be at work here, in addition to Martin’s metaphors. The women may have acquiesced to their doctor’s suggestions, because the *biomedical model* of menopause—that is, thinking of menopause as a medical condition in need of a treatment—is the dominant framework we use in our society when thinking about women’s bodies in menopause. And this framework exists because in our society, we regulate who has the right to speak on a particular topic, what they can talk about, and where they can talk (Foucault, 1972, p. 216). In the case of women’s health and menopause, we listen to medical doctors, because we have deemed them to be competent voices of authority. And as medical textbooks frame women’s bodies in terms of the metaphors I discussed earlier, and physicians learn from those texts, it makes sense that lay people would acquire the medical jargon used by physicians and use a similar framework, the biomedical model, when thinking about bodies in menopause. The biomedical model of menopause therefore serves to contextualize a woman’s knowledge base and problem solving of this event.

#### Age-Grading Bodies-in-Menopause

Narratives that circulate in our society about middle-aged women generally portray a woman’s story as one of change in terms of decay, decline, and desperation (Gergen, 1990, p. 487). One marker for the beginning of this story is the onset of a woman’s menopausal symptoms. Women are labeled healthy, vibrant, and viable during their reproductive years, but once their ability to produce babies has diminished, they are suddenly labeled old. Menopausal discourse seems to age-grade women and is associated with women’s physical aging (Gullette, 1994, p. 97). When the women spoke

about menopause, I heard them speak in terms of the narratives of decay and decline. For example, when discussing what menopause meant to her, Alexandria explained:

Starting menopause made me realize that I'm getting older, that word o-l-d. Oh, I don't think it bothered me about getting older. I know I just wanted to—I've always said I wanted to look good. I never wanted to be overweight. I didn't want to be a fat sloppy mother, like not take care of myself. So my weight was always kind of important. And even though I had gained weight, I seemed to carry it pretty good. . . . And I think I just went with the flow, you know. I mean I just had to do what I had to do. So I went to the doctor and got the pills and tried to do what I could so I could function every day. . . . But you have to face reality, because nobody knows how long we're going to be here. You want to live each day well and good, and to the fullest, to enjoy everything around you, especially your children and grandchildren. Grandchildren complete the circle of life.

That's what we've waited for.

Alexandria's story is one of loss and decay, certainly. But as she entered the menopausal stage of her life, she continued to self-regulate her body as an object of desire for the male gaze by trying to remain slim. And implicit within her story was the idea that HRT would help preserve her body for a while longer, buying her some extra time as a desirable woman.

During a focus group session, Anna spoke of her body in decline as a loss of attractiveness:

I feel as though at my age, anybody my age, a man my age, even 20 years older is looking for a younger woman. They are not looking for somebody who is in her

50s. There is such a, we are so into youth, no matter what they look like. If you are 30, you compare a 30-year old to a very attractive 50-year old, they are going for the 30-year old.

Stephanie countered Anna's concerns with a compliment, stating "you are very attractive, almost movie star attractive. Nice bone structure and you are little." And I added how beautiful her skin looked. It appears that Anna, like so many other women, has bought into the traditional framework of thinking about menopausal women as being over-the-hill once they reach a certain age or stage of their lives.

Ruby, who just turned sixty but looks like she is in her late forties or early fifties, explained menopause in terms of limitations:

Yes, I just turned sixty. I don't look at myself. . . . I guess even when I think it and say it, because I have people say, "you are kidding." And my older daughter, who will be forty in April, if we walk down the street, nobody would ever suspect. Although, because she is bigger, I think that she looks a little bit older, probably. I guess I am blessed with some fairly good health, so I don't feel like I'm sixty. I didn't admit I was old until I wrecked my knee falling off roller blades and I just did that last year. I could hang in there with my kids and my grandkids, and I think that hit me. . . . I still haven't gotten back on them and I haven't given them away. I don't roller blade anymore, and I wish I did.

Ruby recognizes some limitations in that she can no longer keep up with her children's and grandchildren's activities, but she also believes that she has outmaneuvered societal expectations that she look or act a certain way at the age of sixty. She tells us that she looks younger than her age and that most people can't guess her real age. And she

reports that she had been performing activities, such as roller blading, that we normally associate with younger people. Ruby, too, has bought into the traditional, medical model of understanding women's bodies that tells us that older women should look a certain way or act a certain way, but she has figured out a way to cheat the system.

I noticed that many of the women complimented one another on how young they looked for their age, or how beautiful their skin was. For example, during a focus group session, I complimented Stephanie on her wrinkle-free complexion. And when I mentioned to Alexandria that I was in menopause, she responded, "Well, you're too young to be. I think you're just too young to be." In another focus group session, several of the women asked me my age. When I responded that I was fifty-five, Jane marveled that I had the best skin. Another woman asked me if my skin was so clear because I was using estrogen.

I find the women's comments on age and attractiveness intriguing, because a woman's ability to make sense of and frame her experience in menopause and her body is affected by discursive formations that circulate in our society. Age-grading menopausal women, regarding them as over-the-hill and unappealing to men, are examples of the discourse that frames women's bodies. Michel Foucault (1972) explains that discourse is an event managed by society. For Foucault, knowledge is all that is possible to speak about within any given discursive formation. This is so because we regulate and control who has the right to speak, and what each person is allowed to speak about. For example, as I mentioned earlier, we give doctors the power to speak with authority on medical issues. We also define women according to the knowledge, which we also call truths, that we have circulating about them. In our society, we attempt to exclude topics that do

not conform to what we consider to be the truth (1980, p. 131). We do this through what Foucault (1980) calls “regimes of truth” (p. 131), which are systems of power that produce and sustain the dominant “truths” or knowledge in our society. For example, the medical community has two competing models of treatment for women’s bodies in menopause. We have the traditional medical view that favors use of synthetic forms of HRT and the non-traditional or alternative medical view that favors the use of natural methods of HRT. Our society generally favors the traditional medical view, as this is the view that has met the conditions for truth in our society. This same idea applies to the knowledge and truths we have circulating in society about a woman’s body in menopause. And this process is recursive, in that when we use the terms circulating about older women, for example, we strengthen this truth, thereby reproducing and sustaining these discursive formations. Essentially, we try to box in knowledge and self-regulate ourselves through discursive formations in our society.

This would account for Anna’s comments that a woman in her 50s is no longer attractive to men 20 years older than she is. This would also account for our belief in menopause as an estrogen-deficiency disease in need of treatment. All of these ideas are a part of the discourse that we believe to be true about a women’s body. As I mentioned, when we buy into this understanding of our bodies, we strengthen that framework. When we acquire the terms and language that society uses to define menopausal women as “old” or “over-the-hill,” we also strengthen the medical framework surrounding women’s bodies. So I wonder whether the propensity for the women in my focus groups to compliment one another on how good they looked or how vibrant they were for their ages, was an attempt for the women to disperse or break through the traditional truths and

framework that define menopausal women in our society. I think the women were attempting to resist the age-grading discourse on women's bodies in menopause. But grounding their attempts to resist or break out of this discourse is the idea that they have bought into this age-grading discourse on menopausal bodies. They appear to believe that *other* women who are 60 or in menopause should look or act in a certain way, but that *they* have been able to cheat or break through that age-grading framework by keeping their bodies younger-looking. This is a complex issue that is difficult to sort out, because our attempts to keep our bodies younger looking, for example, by dyeing our hair or going to the gym to exercise, indicate that we, too, have bought into the age-grading framework for older women. And with these actions, we are attempting to cheat the system. Believe me, when my gray roots begin to show at the end of each month, I run to the hairstylist for a fresh coat of "hope-to-look-younger" hair color. And when Stephanie and I bemoan the extra weight we are holding, or talk about our bodies not looking like they did when we were younger women, we are also buying into the age-grading framework for older women. I also heard this age-grading framework when I told the younger participants, Bunnie and Jane, that they were way too young to be having problems associated with menopause, as they were both in their thirties. So, it's very difficult to move away from or outside this age-grading framework for women's bodies.

The women talked about sex in terms of reduced desire. Jane had a difficult time with sex because she was taking too much estrogen and getting headaches from it. Stephanie explained, "I'm still having sex. Sex is just fine. I don't want to have sex, but it's still kinda okay and fun and I feel like it is a healthy thing to do. That hasn't changed . . . but I feel like it's like being regular, going to the bathroom almost." Bunnie also lost

interest in sex. “I’m not interested. I mean, it’s nice. Great, sometimes. But most of the time I’m so tired. There are so many different things I need to do. So that’s the last thing I want to bother about. You know? Come on, at the end of the day I just want to rest.”

Malika also lost her desire for sex. “There’s nothing. I am not interested in my husband. I am not interested in anybody or anything.” I, too, noticed that my sex drive had decreased, but it seemed to come back once I started taking HRT. Alexandria stopped having sex when her husband’s heart medication caused him to have erectile dysfunction. For Ruby, vaginal dryness and her partner’s erectile dysfunction were major challenges, but they have been able to overcome the problems with a lot of coordination.

Loss of or lower libido can be a symptom of menopause (Nappi et al., 2001).

And all of the women spoke about some type of change in their desire for sex since they became menopausal: the result of a medical condition, a problem with their HRT formula, excess weight, or simply a dwindling desire. They also spoke of vaginal problems related to intercourse such as vaginal dryness, decreased vaginal lubrication, and loss of vaginal elasticity. But during the final interview process, I discovered that some of the women had other reasons for their lower libido. For example, during our final one-on-one interview, Bunnie confessed that she had decided to leave her husband, and Anna, who had recently divorced her husband, was relishing her independence from men. Malika never specifically mentioned that she and her husband had become estranged, but I had made a note to myself after our final interview that her conversation about her husband seemed to indicate that he might not be visiting her in the States for a very long time.



Before the findings of the WHI were published, most of the women primarily relied upon their physicians for information about menopause. Many of them also read newspapers, searched the Internet, and garnered information from friends or other health care professionals such as nurses. And before they decided upon an initial menopausal treatment option, they had conferred with their physicians or were told by their physicians to take HRT. After the WHI results were published, the women appeared to take control of the decision-making processes related to their bodies and menopause.

Stephanie relied on her doctor for advice, but made her own decision on what changes to make in her medication after she read about the WHI findings. “My doctor asked if I would like to switch over to something else because of all of the dangers associated with estrogen [after the findings of the WHI were published]. He said that I could try progesterone, plain old progesterone, for a while.” She tried progesterone but her vulva itching returned. She took herself off her prescription progesterone, as it wasn’t working for her and consulted her doctor again before deciding to return to HRT.

So I caught my doctor in the hallway and I said, “I think I want to go back on the Prefest.” He said “that’s fine. You have to do what makes you feel good. If I were a woman and I had symptoms, I would probably take estrogen too.” I envision taking HRT as long as they keep my symptoms at bay, and I don’t know how long that is going to be. It’s made a big difference taking HRT. I plan to stay on it as long as I can.

Alexandria, like Stephanie, assumed greater agency once the WHI was published, deciding to go off HRT. The WHI results put a scare in her.

I called my doctor after the Crosstown forum and told him what was discussed and what was happening, and he said go ahead and gradually taper the medication off. Do it in a few weeks time, and you'll be okay. So I did, but I didn't taper off slowly. I went off quicker than he said. He told me to get something from the drugstore, one of the natural things. I can't remember what it is now, because I took it for a short time. I did get some hot flashes at first, but I didn't have terrible hot flashes and I wasn't pulling out my hair or anything like that. I was okay with it. I feel like I'm okay. I'm over it now.

Alexandria is no longer taking HRT.

Anna, who didn't want to take HRT, began taking HRT on the advice of her doctor, but quit when she heard the WHI findings before consulting her doctor: "And then the study came out . . . And as soon as that study came out, that was my ammunition to quit. I called them [the doctor's office] and told them I was going to quit. But I had, of course, already quit . . ." She is no longer taking HRT, but continues to take an antidepressant.

Jane wasn't too concerned when she read the results of the WHI in the news. She explains:

I have to be honest. I did not call my doctor the day I read about the thing [WHI], because I knew they were getting thousands of phone calls. But I made an appointment to visit my OB-GYN at the time and my internist about a month later. I figured what are four weeks going to matter? I really wanted to be able to sit down and talk with both of the doctors instead of being passed through. And I knew they had to be getting a gazillion calls. But after sitting and talking with

them and reading a little bit more about the research, it doesn't [bother me]. I mean there were lots of women, and the demographics showed other things, other health issues. Age factors—and a lot of them were overweight. A lot of the women had health problems, heart problems, and blood pressure problems. So, it wasn't necessarily a good generalization, I don't think. . . . All of the doctors I've gone to say that the risks are far less than the positives that I am getting from being on the HRT. And it sure does make me a little bit more sane and my family probably appreciates it too!

Ruby cut her dosage in half as a result of the WHI findings. She had been taking Prempro, which was the HRT formula that was implicated in the WHI results. She explains:

I told [my doctor] that there was some discussion about taking nothing. You know, I've been on Prempro since I was 50 and was just at the point where I was beginning to cut back when I saw an advertisement for the seminar on menopause and very shortly afterwards the articles came out about how bad HRT was for you. Prempro was probably the worst one and frankly all of my friends were taking something else. By that time, I figured I had been on HRT for 7 years, so if they were going to kill me, maybe I would have been dead, so I kept taking them. I won't say I didn't worry about it, but I didn't immediately make a change because I wasn't going to a doctor on a regular basis at that point. I told the doctor that I had cut my pills in half. In other words, I'm taking one every other day. She was basically totally non-committal. And as far as the testing that went on [WHI] and everybody getting hyper about it, I don't think she was

overenthusiastic about the testing results. She said it was very few people [who showed symptoms] and they were bigger people that probably might have had more of that [heart problems] in their family.”

Ruby is currently taking Prempro.

I did not make immediate changes when I read the results of the WHI in the news. I stayed on my Climara patch and Prometrium for a while longer, but eventually took myself off HRT. I am currently not taking anything to alleviate my uncomfortable symptoms of menopause, and I continue to suffer from severe hot flashes and night sweats.

In the previous sections of this chapter, I examined women’s sensemaking regarding menopause, and discussed how their sensemaking has been couched within a dominant paradigm—the biomedical model of health care. The primary theme of change emerged in their stories, which they experienced largely as decay, decline, and loss. I analyzed the women’s talk using Martin’s medical metaphors and Foucault’s ideas on discourse in order to explain the foundation for the women’s sensemaking on menopause. In the next section, I examine women’s sensemaking in terms of their thinking about their bodies in menopause as a result of the findings of the Women’s Health Initiative. To achieve this end, I examine the women’s descriptions of the changes they undertook to determine whether they changed from the biomedical model of health care or changed their perspectives in relation to the medical metaphors that I discussed earlier.

## Change and Reframing

Watzlawick, Weakland, and Fisch (1974) describe change in terms of a dialectic of persistence and change, and they focus on change as “reframing” (p. xiii). The authors postulate that persistence and change are complementary processes that ought to be considered together, as both contribute to problem solution and problem formation in human relations. We have a tendency to view either persistence as the norm, the stable, taken-for-granted position and change as problematic, or vice versa, when, in fact, either persistence or change can be viewed as the problem or the norm, depending upon the individual case and our perspective. Watzlawick et al. developed their ideas on persistence and change as a result of their work in family therapy. Invariably, two questions came to mind when they observed couples immersed in repetitive problems: “How does this undesirable situation persist? and What is required to change it” (1974, p. 2)? The authors were not concerned with the “why” or the historical, background information related to the problems, but rather, they sought interventions that could help the parties change. The authors discussed two distinct types of change: *first-order change* and *second-order change*. Both types of change, and the distinction between them, will provide me with a framework for analyzing the women’s sensemaking on menopause and the WHI.

First-order change is change that is concerned with members of a group or system and their relationships to one another within that group or system, so that any change within that group or system, or with any of the members of the group or system, does not result in a change of the group’s situation or problem. The authors refer to this as first-order change: a change within a group or system that otherwise remains the same.

Second-order change is concerned with the totality of a class rather than with a group or system, or with the individual members of that group or system. The authors refer to a change that transcends the boundaries of a system or group at a meta level as a second-order change. One of the interesting aspects of a second-order change is that “going from one level to the next higher (i.e., from member of a group to a class) entails a shift, a jump, a discontinuity or transformation—in a word, a change [that] provides a way out of a system” (Watzlawick et al., 1974, p. 9). This is reframing.

The authors use the example of a dream, a nightmare, to explain the difference between first and second order change. If I am having a nightmare, I might try to change my dream by running, jumping, or hiding, but no matter what change I make, I am still in the nightmare. Any of these changes I mentioned are considered first-order changes, as they don't affect a systemic change or a change in my behavior called dreaming. But if I terminate the nightmare by waking up, then I have affected a change that is not a member of the group. I have affected a second-order change, as I have provided a way out of the system.

Second-order change is an everyday phenomenon, more common than we might imagine (Watzlawick et al., 1974). But, to accomplish it, we must step out of the boundaries of our framework and into a new one. And because we must reframe, second-order change may appear illogical, but only in relation to the boundaries of the group or system we are part of and the first-order changes we make within that group or system. Second-order change means that we step outside that systems' rules and borders in order to solve a problem. Second-order change is more significant change, as it is the only way that one can solve a problem, whereas first-order change rarely solves a problem and

often makes things worse because the problem remains contextualized within the same framework.

I heard the women talk in terms of change, certainly. They spoke of changing from one HRT formula to another once the findings of the WHI were published. For example, Stephanie changed from using Ortho-Prefest to using progestin alone once the WHI results were reported. But, even though she changed the type of hormone, she framed her thinking in terms of the biomedical model of health care. Her change was a first-order change, that is, a change that stayed within the boundaries of the system. Another change some of the women made was to move from prescription-based, synthetic hormone therapy to natural, bio-identical hormone therapies. For example, Jane began using bio-identical hormone therapies, and expressed a desire to explore natural therapies in more detail in the future. She too was definitely making a change, but because she was still adding estrogen and progesterone to her body, the potential health problems associated with HRT and reported in the WHI findings remained the same. And she was still operating within the biomedical model of health care, in terms of thinking of her body as estrogen deficient and as a vessel to top off with fluids. In this case, the system has not changed and the frame remains the same. This too is a first-order change, an example of what Watzlawick et al. (1974) term “more of the same,” as the underlying framework remains the same.

Some of the women made their own decision regarding whether to continue taking HRT medication after the WHI findings were published. For example, Stephanie decided what HRT formula to take, when to take it, and when to return to her old formula. She made a change, assuming greater agency over her health care rather than

relying on her physician to make decisions about her body. In an earlier section, I mentioned that we give doctors the authority to control the health care conversation in our society, and it appeared that Stephanie was breaking through this authority. Thus, this might lead one to conclude that she was reframing by making a second-order change, a change that transcended the boundaries of the biomedical model. Her thinking, however, continued to be framed within the traditional, biomedical model of health care even though she made the decisions. In this instance, although she didn't use the words of her physician to direct her thinking, she had incorporated the "knowledge" or "truths" we have circulating about women's bodies into her thinking process. She essentially self-regulated her decision-making concerning her body in terms of the dominant medical paradigm. This process of self-regulating our decisions in terms of the discursive formations in society is a form of surveillance of our selves and our bodies.

Anna and Alexandria, also took greater agency in making decisions about their bodies after the WHI findings were published. They took greater agency and they also took themselves off of their HRT formula. Anna took herself off HRT before calling her physician to talk about the WHI findings. She had changed her thinking about her body in menopause and HRT. And did so without consulting her physician. She had found a way out of the biomedical model of medicine framework and reframed her thinking, thereby making a second-order change, a change outside the system. Alexandria also took herself off HRT, thereby making a second-order change, even though she did talk with her physician about it. She too had found a way outside the boundaries of the biomedical model of health care and made a change that transcended the boundaries of the biomedical model of health care.



Emily Martin's (2001) metaphors are useful in considering the women's reframing. In an earlier section, I mentioned that some of the women changed from one type of HRT to another, such as Anna, who changed from using Prempro to the Vivelle-dot before the WHI findings came out. At that time, she was operating within the "body-as-a-machine" metaphor. When the women used terms associated with the biomedical model of menopause, such as "estrogen-deficiency" or "ovarian decline," they, too, were operating within the biomedical model and were strengthening the boundaries of that biomedical frame. Before the WHI findings were published, the women's physicians suggested alternate kinds of medicines to help with menopausal symptoms, either in addition to HRT or in lieu of it, such as sleeping aids, mood-controlling drugs, and drugs to help with bone density. In all of these situations, the frame was the biomedical model. The physicians also suggested alternate kinds of medicines to the women after the WHI findings. For example, Anna stopped taking HRT but eventually began taking an anti-depressant, and Jane added an anti-depressant medicine to her HRT medicine regime. Both of these women made changes, but they were "more of the same"—first-order changes, as the women were still thinking in terms of the body-as-a-machine metaphor.

In terms of the women's sensemaking, once they had time to digest the findings of the WHI, I discovered that some of them expressed a concern that their bodies will suffer adversely as a result of taking HRT in the future. For example, Stephanie explained:

I have learned that HRT could be dangerous, if you have a propensity towards breast cancer, but that hasn't stopped me [from using HRT]. . . . There is always the nagging concern that maybe it's going to cause problems that you wouldn't

have had otherwise. . . . I think I feel somewhat immune because I don't have a history of a lot of bad things.

Anna, on the other hand, was concerned that her body will suffer adversely in the future, because she isn't taking HRT:

I wonder, are we silly for not taking it [HRT]. Are we going to end up all wrinkly if we do live to be 90? But don't we have medication for our bones and better studies to assess whether we have osteoporosis. If we are smart, we are keeping track of our hearts and we won't get heart disease.

Jane was confused, because she was given conflicting information:

I'm probably more confused than anybody on what to do with that, you know.

Some people say, "Okay, you are 39. It's been two years on it, you should definitely be off." But others say, "You are only 39, and you should really be on it a little bit longer." And you know these are people who are reading all of the medical research. I'm not qualified to go and read all of this medical research. So you are really up in arms. You need to be your own advocate when it comes to the medical community. But it's hard when you are—I feel challenged, because that is not my educational background and I don't have all of the tools at my fingertips. So the best I can offer is to go to the doctor twice a year, and see what the latest and greatest of what they are finding out is. I do want to track down, and you may have this in your notes, . . . the doctor that Bunnie went to in Brandon. I would like to track that down and go and talk to him. Just because Bunnie was so impressed with him, and he seems to be focused on that

[menopause] and I think some of it is you need to find someone . . . who focuses in on that.

Alexandria feels let down by the medical industry:

Yeah, well, certainly taking hormone replacement therapy didn't help my heart because my first gynecologist says, "this will be good for your heart, just in case, since your mother had problems. This will be good for you." But come to find out from that article [on the findings of the WHI] that it might be a worrisome thing. At first they're telling you to take, take, take this, you've got to have this, and then the next thing you know, down the road a year later or so, they are saying don't do this or don't take that because ta-da, ta-da, ta-da, this is going to happen to you or you're going to get this if you take it. And it makes you feel like there's something wrong with the pharmaceutical industry. They seem to be rushing to judgment by saying "yes, HRT is okay," and people are waiting for the miracle and the cure. . . . I'm not taking it and won't if it's going to cause any other problems or future problems of cancer or whatever was mentioned.

Ruby was mainly confused over future prospects for medical information on HRT:

My bigger problem with this is what are they taking now? And are they going to come up with a study in 5 years to say that everything women are taking now is not good for them because it is all new stuff? My other concern would be the fact that I have been taking it now for about 10 years. That, I think, was the other thing that my doctor agreed with. If I were going to have a problem, it probably would have happened already.

And I am concerned about my body. I continue to be concerned about the effects of not having enough estrogen to nourish my vagina. Will I endanger my body down the road without estrogen? Will my bones become brittle without estrogen? Will I develop osteoporosis without estrogen? But I firmly believe the risks of taking HRT outweigh the benefits, in my situation. I am afraid I might develop a heart condition down the road if I were to have continued taking HRT. And, if I develop a heart condition later, I would never know if I caused the problem by taking HRT.

Alexandria appears to be the only woman in the group who was able to free herself of the biomedical model of medicine, in terms of thinking about HRT and menopause, as she was the only one who was not concerned with stopping her medicine and not replacing it with another form of hormone medication. She broke out of the body-as-failed-production metaphor. And she didn't appear to regret her decision. Anna and I, on the other hand, stopped our HRT, but we continue to think in terms of our bodies as estrogen deficient and to worry about the future health of our bodies as they age without the benefits of HRT.

This conversation about women's bodies-in-menopause will continue, I imagine, until we are able as a society to reframe the way we think about women's bodies. But there may be hope for change, according to Foucault (1980):

The problem is not changing people's consciousness—or what's in their heads—but the political, economic, institutional regime of the production of truth. It's not a matter of emancipating truth from every system of power (which would be a chimera, for truth is already power) but of detaching the power of truth from the

forms of hegemony, social, economic and cultural, within which it operates at the present time. (p. 133)

Foucault's analysis suggests that it is possible for our society to reframe the way we think about women's bodies in menopause—to break through the biomedical model of medicine and change the age-grading discourse that circulates about women's bodies in menopause. We can do this through discourse. But in order to achieve this end, we need to make a second-order change, or a change that transcends the boundaries of our current way of thinking about women's bodies in menopause. I don't know exactly how this might be accomplished, except by one woman at a time talking and thinking about her body in ways that resist the dominant paradigm, so that we can hear new voices about women's bodies in menopause.

In this chapter, I discussed the women's framing and sensemaking regarding their bodies in menopause. In the next chapter, I discuss the final words the women had about their bodies in menopause and provide a few closing remarks about my study.

## CHAPTER FIVE

### FINAL PERSPECTIVES

In the previous chapters, I examined how the women in my study have been making sense of menopause in light of the recent findings of the Women's Health Initiative (WHI). In this chapter, I discuss the women's overall ambivalence regarding menopause, describe their hopes for the future, list avenues for future areas of research, and discuss a few final reflections and impressions of my research project.

#### Ambivalence

During the interviews and focus groups, the women shared a variety of concerns with me and discussed many issues related to their bodies in menopause. Frequently, they spoke about menopause as bringing changes, especially decay decline, and loss: over aging bodies, failing health, and lower libido. Throughout our discussions, the women spoke about the contradictions and dilemmas they faced as they tried to sort through the conflicting information they have been receiving about the effects of menopause and HRT on their bodies. Some expressed a concern for their health because they had been using HRT before the findings of the WHI were published. Others expressed a concern for their health for taking HRT after the findings of the WHI were published. But regardless of whether the women chose to continue HRT or decided to quit taking it, they were perplexed over their futures. The women felt as if they were flying solo, with no clear flight plan as to how to take good care of their bodies as they

aged. I, too, felt the same frustration and shared many of the same concerns as the participants. It is difficult to make sense of issues surrounding menopause and our health, especially because both appear to be bundled tightly together. And our menopausal bodies are also contextualized within the discursive formations I discussed in an earlier chapter. It is as if we are trying to steer through dense fog late at night with the high beams turned on: as hard as we try to illuminate the path ahead, we are left instead with a murky view of what is in front of us. Several of the women summed up this ambivalence:

Anna: But that is how it is now, I mean, nobody knows for sure if we should be on it or not. That is where I'm uncomfortable now, if we are doing the right thing or not. Should we be on HRT or not, you know? I'm not, and that worries me, but yet I don't want to be on it either, so it makes you wonder.

Stephanie: I thought well, maybe I ought to go off and see how I feel. I was afraid to because I think in my mind I feel like HRT is some kind of elixir of youth that would prolong any positive effects of premenopause. And I didn't want to do it, but you can't help but want to experiment a little and see if there would be any repercussions.

Alexandria: It seems like I got through it, I guess, okay. Like I said, if it hadn't been for those horrible pills, that we now know were horrible. At least it helped me get through it. I was able to work at my job and able to function at home.

In the end, the women were left with little to comfort them as they tried to sort through the conflicting and often contradicting information over HRT, the WHI, and how to take care of themselves as they entered this menopausal stage of their lives.

## Wishes

I asked the women to tell me what they would wish for if they could wave a magic wand and have anything about menopause addressed. Here are their voices:

Malika: Make it be easy. Few hot flashes. No night sweats.

Bunnie: Let it be fast. Why does it have to start so early? That it doesn't happen at all. The transition sounds so difficult, why does it have to happen that way? Let it all be clear.

Anna: If I'm gonna live to be old, I would like to be healthy. If all of these changes mean that something is going to happen to me down the road because I did or did not take HRT, I just want to be healthy.

Stephanie: If I could just be like I was—and I don't mean looking and all that stuff—but if I didn't have to worry about taking a pill. It's always nice if you can eliminate a pill in your life and if I could have the symptoms alleviated without taking medication.

Ruby: I wish I didn't have the dryness.

Jane: I guess the mood swings that I'm starting to get. That would be nice. To breeze right through it. Not have it!

I heard in the women's wishes confusion not only about how to manage this stage of their lives and how to cope with the uncomfortable symptoms associated with menopause, but also ambivalence over a bodily process that is a part of being female. I hesitate to label this female bodily process as "natural," because it's impossible to separate fully the body from the discursive formations in society that frames the way we think and talk about a woman's body. I do continue to wonder how much of the way the



women made sense of their bodies in menopause is the result of the way we construct and control women's bodies in our culture. It is as if our bodies were made of soft clay, to be kneaded and shaped by the powerful hands of society, until we have been molded into one-size-fits-all cookie-cutter shapes and consumed by our culture. This would account for some of the concerns I heard the women express in the focus group and individual interviews about wrinkles, weight, or general attractiveness. There is also a recursive nature to the construction of our bodies, and, as we participate in the construction, we reinforce the boundaries of this framework. Unfortunately, rejecting our bodies starts so early in life. I am in my fifties now, but I can vividly remember how I felt at the age of ten on the day I had my first period. I was alarmed and terribly embarrassed to have so much blood gushing out of me. I didn't know what to make of this event or of my body. And even though my mother celebrated the start of my period by taking me out for an ice-cream sundae, it didn't seem fair to me that I would have to tolerate such a bloody mess month after month for years and years to come in the name of "growing into a woman." I felt a similar sense of embarrassment and alarm when I was forced to wear my first bra. I remember that I hated having something foreign tightly wrapped around my back, so every day on my way to school, once I was outside my mother's sight, I would hurriedly exchange that tight brace around my body for the comfort of a soft, cotton undershirt. So, as an innocent young girl, I tried to resist, in my own way, at least one of the rules governing the female body, but in doing so, I wonder if I was also starting to reject my female body.

## Future Areas of Research

I have several ideas for future research projects on my topic. I would like to talk with physicians to discover what they are telling their patients about menopause, HRT, and the WHI. I would want to talk with physicians who work within traditional medicine and those who work in alternative medicine. I would also want to talk with physicians who work with insured patients and also with those who work with uninsured patients.

I would also like to talk with women from different demographic backgrounds, such as women of color, women with lower educational levels, lower-income level, and women who rely on health clinics for their medical needs. I would, however, want to continue to work with women who were in some distress as they approached menopause, as these women in my study were, even though I did not set out to intentionally select women who were in distress. But I did so inadvertently when I selected women from those who had attended the seminars in the Tampa Bay area after the WHI findings were published. This feature of my study departs markedly from Emily Martin's findings. The women in her study did not find menopause remarkable, as the women did in my study. The women in her study were not experiencing uncomfortable symptoms. Some may have been taking HRT, but as her study was completed long before the findings of the WHI were published, none of her participants had been told that HRT could be a big problem. I imagine, otherwise, she might have had some distressed women too, concerned about osteoporosis, for example, or vaginal dryness, once they stopped taking HRT. I would, therefore, hope to continue a conversation with the participants of this study, and possibly to contact them again in 5 years to see what their current thinking is on menopause, HRT, and the WHI, and to learn whether they do eventually forge a path

toward using language that doesn't age-grade bodies in menopause. And I would also hope to interview the participant's husbands or partners, or the husbands or partners of other menopausal women, to see how they are making sense of bodies in menopause.

### Final Words

I asked the women how they would like me to remember them and found their final thoughts filled with hope for their futures:

Jane: As someone who is living life and not getting upset about this situation, because this is still a work in process. And the research is still a work in process and even though you turn the television on and some days there are horrifying new discoveries, you just can't go there. I mean, they don't know enough yet. There hasn't been enough research done yet. People haven't been followed enough yet. Sometimes you have to take what the media says with a grain of salt. Sometimes they have a tendency to go over and beyond.

Anna: As a strong woman who isn't going to let lack of estrogen get me down, or slow me down. I'm on my own and I have to do for myself and I'm going to do it. But I think we need to keep educating ourselves because everything changes so much. Opinions change and then these studies change. That bothers me.

Stephanie: As someone who is compassionate, yet not too self-sacrificing. I don't want to destroy myself in the process of trying to give back to the world. I certainly don't want to be thought of as being menopausal. I would like to be thought of as healthy.

Ruby: Life is good. Menopause just isn't a big part of it. It doesn't bother me. I got on track with whatever I did when I turned 50, and 10 years later, I'm not

unhappy with it. I just still take it. I modified it to suit me. But life is good. And it's been a long time coming.

I began this research project as a result of my personal journey trying to cope with and make sense of the menopausal stage of my life. I wondered how other women were making sense of their bodies as they entered menopause, especially as there has been so much conflicting information circulating about how to understand our bodies and how to keep them healthy during menopause. For a time, HRT appeared to be a panacea for the menopausal women, as it was heralded as a vehicle that could help a woman maintain her youth, beauty, and health into old age. When I first exhibited symptoms of and talked with a health care professional about menopause, I, too, was encouraged to use HRT to replace my estrogen deficiency in order to stay “healthy” into old age. But the findings of the WHI forced me and other women to reconsider our ideas about HRT, health, and our bodies in menopause. Through the individual interviews and focus group discussions with my participants, I hoped to answer several questions: What experiences with menopause did the women talk about? What common themes or categories arose? How did the individual women make sense of the conflicting information circulating about their bodies in menopause? What role did the WHI play in their sensemaking?

I discovered that the stories the women told about their lives in menopause were stories about their overall well-being at this point their lives, as they, like me, found it impossible to separate menopause from the general state of their lives. And so we talked about our families, our work, our relationships, and our hopes for the future. The women talked about vaginal dryness as readily as they talked about going through marital changes. They talked about hot flashes and night sweats juxtaposed next to the

wonderful support (or lack of support) they were receiving from their partners. They talked about various HRT treatment options that were available, and their opinions about these options, in addition to the dilemmas they faced trying to discover a label for some of the symptoms they were experiencing. They discussed alternate treatment options with one another, while talking about the struggles they had trying to find a doctor who was sympathetic to their situations. Sometimes the women talked about change in terms of loss: loss of libido, loss of elasticity of their vagina, loss of a marriage, loss of children, loss of their health as other types of health problems began to assert themselves, such as heart disease, diabetes, and high cholesterol. We talked about the realization that we were getting older and what that meant to us. I discovered that framing and sensemaking is an ongoing process and is subject to change and repositioning and reorganization as we continue to struggle with making meaning in our lives. I learned that the women continually tried to change their situations in ways they thought might improve their lives, such as trying different remedies, or trying to take care of their bodies on their own by rejecting the traditional HRT remedies. Some of the changes I saw the women make were first-order changes. For example, if a participant saw her body as deficient in estrogen or if she changed her HRT formula, the framework for her change remained the same and the problems she may have been experiencing also remained the same. In these instances, the women's sensemaking remained grounded within the biomedical model. But I did see some indications of second-order change. For example, one of the women stopped taking HRT, felt good about her decision, and didn't worry about future health repercussions of her decision. But mostly, I discovered a courageous group of women who confronted daily challenges coping with negative

messages from a society critical of the aging, female body—a society that thinks less of a woman simply because she no longer menstruates, is showing a few gray hairs, or has a few extra pounds.

When I reflected upon the women's frameworks for making sense of their bodies in menopause, I couldn't help but imagine that a chasm existed between what the women said about their bodies and how they hoped to frame their bodies in menopause. For example, some of the women appeared to resist the age-grading language circulating about women's bodies in menopause when they talked about not feeling their age, or looking younger than their years, yet, making statements like these served to ground their way of thinking about bodies in menopause within the very age-grading language that they appeared to resist. The same is true when we couch our sensemaking in terms of the biomedical model of medicine or within the medical metaphors discussed in previous chapters. I'm wondering, therefore, whether women's sensemaking about bodies in menopause continues to mark a point of incommensurability in our society where we don't yet have a framework that allows for differing perspectives to be put into words. Our sensemaking on menopause may constitute what Lyotard (1988) called a *differend*, an "unstable state and instance of language wherein something that must be able to be put into phrases cannot yet be" (p. 13). But I see hope for the future, in that the more we allow differing positions and different voices to be articulated, as I have tried to do with my project, the more minority and oppositional viewpoints and ways of thinking about and framing bodies in menopause will begin to circulate in society, developing new discourses about menopausal women. This is my hope for the future and one of the benefits I saw in the narratives the women told me about their lives in menopause.

When I began my journey into menopause, I noticed that I had developed a problem concentrating. I confided my worry to my gynecologist and asked her if this would be a permanent state of my mind in the future, now that I was going through menopause. She told me, “no.” She said that women who have been through menopause have gone on to achieve great accomplishments in our society. Her words comforted me that day, and they continue to offer me hope for our, and my, future.

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## Appendices

## Appendix A

### Telephone Screening Interview Script

Name of Interviewee \_\_\_\_\_

Hi, my name is Linda Vangelis. I'm a doctoral candidate at the University of South Florida. I'm following up on our discussion about possibly interviewing you for my dissertation project on hormone replacement therapy, menopause, and the Women's Health Initiative. You may or may not remember talking with me, but I met you at the \_\_\_\_\_ (Crosstown, WHI; Crosstown, Dr. Lee; Tampa General, Parsons; Marriott Waterside; mini-med school at Performing Arts Center) seminar on menopause, and at the time that we met, you said that when I was ready to interview women about menopause that it was okay to call you.

Have I phoned you at an inconvenient time?

I'm not sure if you would still like to be interviewed, but I did want to ask you five or six questions, which will take a few minutes, if that is okay with you.

Then, we can talk about whether or not you would be willing to be interviewed and whether you would be appropriate for the study. Of course, your participation in this telephone interview is voluntary. If you participate or not, there are no treatments involved in this telephone interview, and if you want to stop at any time you may, just tell me and we'll stop.

I will keep what you say confidential. The results of this telephone interview may be published, but the published results will not include your name or any other information that would personally identify you in any way. May I have permission to tape our conversation? Would you state your name for the record? May I have permission to use the results of this interview in my project? Would you give me a pseudonym, a fake name, to represent you, in place of your real name?

How old are you?

Between:      30-35   36-40   41-45   46-49   50-55   56-60   61-64   65 and over





Why have you decided not to use it? (if never used)

Do you follow in the news the number of stories on hormone replacement therapies and menopause?

If no, where do you get your information on menopause and hormone replacement therapy?

If so, what have you learned?

When you think of menopause, what comes to your mind?

I have a few background questions:

Do you work outside the home?

If so, what do you do?

What is your educational level?

(if the woman is not verbal or I decide not to include her, then I'll say: Thank you very much for spending time with me today. I'll put your responses in my study. If you need to call me for any reason, I'll give you my home number and my work number.)

Or,

Let me tell you a about my project then I'll ask if you would be willing to be interviewed:

This is the process: you will need to come to 3 focus group sessions (each one of them 1 ½ - 2 hours). The first one will be held at the Department of Communication at the University of South Florida in Tampa, and subsequent meetings may be held at my apartment, if we feel it might be more comfortable. I'll also interview you on two separate occasions individually (each interview about 1 to 1 ½ hours), and we can meet at a location convenient to you for the one-on-one interviews. I also may phone you from time to time to ask you a follow-up question, or to ask you to clarify a response. I imagine that you will need to spend approximately 9-16 hours on this project. The number of hours will depend upon whether or not you want to attend additional focus groups besides the three that I mentioned earlier. I'll also ask you to sign a consent form, which will give me the authority to use your conversation and ideas in my research.

Would you be willing to be interviewed?

Would you be willing to come to 3 focus group sessions?

What days/times work best for you? As you know it might be difficult to accommodate everyone's schedule, so, I wanted to ask were you feel you might have some flexibility when you think about the days that you might be available.

Let me give you my phone number at home and at the University, so that you may also phone me if you want to. My home number is: 813/914-8464 and my work number is 813/974-2145. I'll also give you the phone number of my major professor, Ken Cissna, so you can contact him, if you want. His office number is 813/974-6820.

If you have any questions about your rights as a person who is taking part in a research study, you may contact the Division of Research compliance of the University of South Florida at (813) 974-5638.

I'll be in touch in a week or so to let you know if I can include you in the study.

Thank you so very much for spending time talking with me today.

## Appendix B

### Screening Criteria for Including Women in the Research Project

1. The phone number I collected is still valid - belonging to the woman I met at the seminar.
2. The woman I spoke with at the seminar last year is either perimenopausal, menopausal, or postmenopausal.
3. The woman is interested in participating in the project.
4. The woman is willing to participate in two face-to-face interviews.
5. The woman is willing to sign a consent form to participate in the study.
6. The woman is willing to travel either to my apartment, to a conference room in the Department of Communication, at the University of South Florida, or to another location for the focus group sessions.
7. The woman must be willing to attend and participate in three focus groups.
8. She must be available to attend the focus group session(s) during the scheduled times for this data collection stage.
9. She must be available for an individual interview on two separate occasions during the time parameters for this data gathering process.
10. She must be willing to invite me to her home for the individual, face-to-face interviews, or to meet me in a public place, or to come to my home for one or more individual, face-to-face interviews.
11. She must appear to be verbal enough for me to understand her when I phone to inquire about her participation in this process.
12. I plan to try to balance women who are/have been using natural and synthetic HRT therapies in the past or the present.

13. I will inquire about a woman's race in an attempt to include a cross-section of women in the study.
14. I want to include older women, that is, women over 65, so I will also be asking for the ages of the women as a possible screening tool.
15. I will be making the decision on who to include based upon how verbal and interested each woman appears to be in the study. And I will also include women who appear to be interested in talking about their experiences.

## Appendix C

### Plan for the One-on-One Interview Including Questions

1. Review the consent form with the participant and answer any questions she has about the process and the study.
2. Confirm her pseudonym.
3. Ask about her availability to attend the focus groups sessions.
4. Explain that today we are just going to spend some time getting to know one another. Tell me a little about yourself and your background?
5. Talk about my own background as it fits into our conversation, if the participant is interested in knowing about me.
6. How did you first realize or recognize that you were perimenopausal, menopausal, or postmenopausal? I may confirm what type of HRT she is/was taking and how she feels about taking it. I plan to follow her lead in our conversation on menopause.
7. Give her a disposable camera. Ask her to take pictures of her life in menopause and explain that I will pay to have two sets of prints made. We will discuss these pictures during our final conversation together. Ask her to bring the exposed film to our first focus group session, so that I can have the film developed. I will give her the negatives and one set of prints during our final interview session. I'll keep one set of prints for my study, but I will not be using her pictures in my study in pictorial format.
8. What else would you like to tell me about yourself?
9. What other questions can I answer for you about the study?

## Appendix D

### Interview Questions for Final One-on-One Interview

1. Tell me a little more about yourself and your background.
2. Earlier, in the focus group, we had a general discussion on how you first discovered you were starting menopausal. In reflecting upon that discussion and your opinions, would you tell me more about your experiences with menopause?

For example, how you came to realize you were becoming menopause, what you did about it, and what you are currently doing about it.

Tell me a story.

(This will be part of the story of the woman's experience in menopause that I hope to capture through the individual interviews and the focus group sessions.)

Did you feel you were prepared for this life event?

How?

How did you think your partner (if you are partnered, otherwise you friend/family) viewed you once they became aware of this life event?

Who did you talk with about this?

What do you now think of when you hear the term menopause, since you have had time to live with menopause?

If you could, what would you like to share with younger women about the experience of menopause?

Why would you tell them that?

3. Let's look at the pictures you took of your life in menopause. Would you please explain why you took these particular pictures?

Why?

Could you be more specific?

Tell me a story

4. Earlier, in the focus group, you had a chance to discuss your experiences with menopause with the other members of your focus group. I would like to ask you how it felt to be a part of that discussion group. How did it feel?

Would you feel comfortable talking with the group again in the future?

Why/why not?

What would you want to share with them in the future that you might not have had a chance to share with them?

5. In the focus group, you had a chance to your thoughts on the Woman's Health Initiative and strategies and changes you may have made as a result of the WHI and menopause. In thinking about your own health, would you tell me how the WHI findings affected your thinking on your health, hormone replacement therapies, and menopause?

Do you plan to go on/stay on hormone replacement therapy (again)?

Why/why not?

What changed your thinking since the WHI findings?

6. I would like to follow up on several of the response you gave in the focus group.

(These questions will depend upon the responses the participant gave in the focus group sessions. Ask follow-up questions that relate to specific focus group responses.)

Would you please clarify that response?

What would you add to that response?

7. What else would you like to share with me about menopause, hormone replacement therapy, and the Women's Health Initiative?
8. What would you like me to remember about your participation in this research project?
9. What do you remember most about the other participants?



10. Would you like to change anything you told the group in earlier sessions?

What?

Why?

Appendix E

Demographic Information

<b>Pseudonym</b>	<b>Age</b>	<b>Menopause Stage</b>	<b>Ethnicity</b>	<b>Educational Level</b>	<b>Type of HRT<sup>6</sup></b>	<b>Term Related to Menopause</b>
Alexandra	65+	Postmenopause	Caucasian	High School	Premarin	Sweats/Flashes
Anna	50-55	Menopause	Caucasian	College Degree	Prempro	Old Age
Bunnie	30-35	Perimenopause	Latina	College Degree	Progesterone Cream	Mood Changes/Sweating
Jane	36-40	Menopause	Caucasian	College Degree	Cenestin	Old Age
Linda	50-55	Postmenopause	Caucasian	Ph.D. (in progress)	Climara Patch	Old Age/Hot Flashes
Lynn	65+	Postmenopause	Caucasian	High School	Premarin	No Specific Term
Malika	46-49	Perimenopause	Caucasian	College Degree	Patch/Pellets	Hot flashes
Mary C.	50-55	Menopause	Caucasian	College - 2 years	Alesse (low dose birth control)	Hot Flashes/Depression Sleeplessness
Ruby	56-60	Postmenopause	Caucasian	High School	Prempro	No More Periods
Stephanie	50-55	Postmenopause	Caucasian	Master's Degree	Ortho-Prefest	No Longer Fertile
Vina	41-45	Perimenopause	African British	College - 3 years	None	Old Age

<sup>6</sup> This is the type of HRT the women were taking before the findings of the WHI were published.

## Appendix F

### Focus Group Introduction and Questions

#### Focus Group Introduction

My initial introduction to the group will include the following statement:

I've asked you to come together to discuss your experiences with menopause in light of the recent findings of the Women's Health Initiative (WHI). I would like to keep our conversation open and as flexible as possible, so that each of you may have the opportunity to share your opinions in your own way, with very little prompting from me. So, over the next hour and a half I would like each of you to share with the group your personal experiences in your stage of menopause, in light of the recent findings of the Women's Health Initiative. I'll probably begin by asking a general question to get our conversation going. Please feel free to move the conversation in any direction you would like to go. And please feel free to share any of your opinions with the group. On occasion, I may interject a question or two to clarify your response or to ask for additional background information. Since I am also a woman in menopause, I will be interjecting my own comments and opinions with all of you as we go along.

Before we begin our discussion, I would like to answer any questions you might have. What would you like to know as we begin our discussion? (Respond to the questions.) Please feel free to walk around, or grab something to eat as we talk. Let's get started.

#### Focus Group Questions.

(The following questions are illustrative of the issues and topics I hope are discussed in the focus groups).

1. As a woman in menopause, (or a woman approaching menopause), would you tell us how you see this stage of your life?

For example, what comes to your mind when you hear the word menopause?

What experiences do you currently have about menopause?

2. What are you doing, if anything about your experiences of menopause?
- For example, are you currently taking anything, such as hormone replacement therapy?
- If so, what are you taking?
- When did you start taking that?
- Why are you taking that, by this I mean, what prompted you to take this?
- Who recommended you take this?
- Who did/do you turn to for help with your decisions?
- Have you changed to anything else?
- What did you change to?
- When?
- Why?
- Who recommended you take this?
- Who did you turn to for help with this decision?
3. Where do you get your information about menopause?
- Have you followed the recent news reports on menopause and hormone replacement therapies?
- What have you learned?
- Were you taking any type of hormone replacement therapy before you heard about the findings of the Women's Health Initiative?
- How did you find out about the results of the recent study on menopause and hormone replacement therapy?
- Now that you have information as a result of the Women's Health Initiative, what are you doing differently to cope with your experience of menopause?
- Why?

What type of support would you like from your health care providers?

4. Where do you get your information about natural methods of hormone replacement therapies?

What makes these therapies natural?

Why did you start taking natural hormone replacement therapies over other types?

Where do you buy your hormone therapies?

5. Where do you get your information about prescription-based hormone replacement therapies?

How are these types of therapies different, in your opinion than others?

Why did you start taking these therapies over other types?

Where do you buy these hormone therapies?

6. How do you feel now about hormone replacement therapy?

7. Tell me about the first time you realized that you were menopausal.

How did you discover this?

What did you feel? Or What tipped you off to this?

Who did you tell?

How did your partner, if you are partnered, react?

If you are not partnered, who did you talk to about this?

8. Has your life view changed as a result of becoming menopausal?

In what way?

Tell us about this.

Tell us a story.

9. What is most important to you when you think about the Women's Health Initiative and your life in menopause?

Why?

Tell use more about that.

10. If you could wave a magic wand and have your deepest concern about menopause addressed, what would you wish for?
11. What do you want from your health care provider in terms of menopause?
12. What else would you like to share with the group about you life in menopause, hormone replacement therapy, and the Woman's Health Initiative?

## Appendix G

### Asking Reflective Questions<sup>7</sup>

1. Have I connected the voices and stories of individuals back to the set of historic, structural, and economic relations in which they are situated?
2. Have I employed multiple methods so that very different kinds of analyses can be constructed?
3. Have I described the mundane?
4. Have the participants reviewed the material with me and interpreted, dissented, challenged my interpretations? And how do I report these departures?
5. Have I worked to explain to the readers the position from which informants speak?
6. Have I considered how my data could be used for social politics/policies?
7. Where have I backed into the passive voice and decoupled my responsibility for my interpretations? Where have I hidden my own authority behind the stories of my participants?
8. Who is rendered vulnerable/responsible or exposed by my analyses?
9. To what extent has my analysis offered an alternative to the dominant discourse.

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<sup>7</sup> This list was derived from Fine et al., (2000, pp. 126-127).

## ABOUT THE AUTHOR

Linda Vangelis received her Bachelor of Science degree in economics and her Master of Arts degree in communication from Northern Illinois University. She worked in private industry in the areas of management, sales, and organizational development prior to entering the Ph.D. program in communication at the University of South Florida in 1999.

As a doctoral student at the University of South Florida, she taught communication courses as a Graduate Assistant in the Department of Communication. In 2004, Ms. Vangelis received the Provost's Commendation for Outstanding Teaching by a Graduate Teaching Assistant. She is currently a faculty member at East Carolina University, in Greenville, North Carolina, where she specializes in health communication, aging studies, and interpersonal communication. She has presented her research at several conferences, including the National Communication Association and Southern States Communication Association.