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A lesbian feminist analysis of the demise of hormone replacement therapy ☆

Jennifer Kelly

Murdoch Childrens Research Institute, PO Box 911, Parkville Vic 3052, Victoria, Australia

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SYNOPSIS

For many years, radical feminists have been warning about the dangers inherent in the use of Hormone Replacement Therapy. Until the release of the Women's Health Initiative results in 2002, these warnings were dismissed and discredited. In this article I summarise these recent debates. In addition, I also draw upon findings from my doctoral research, the first study in Australia to examine lesbians' experiences of menopause, to highlight how lesbian voices and radical feminist analyses of the medicalisation of midlife are overlooked and dismissed. For the purpose of this article, I restrict my critique to the issue of Hormone Replacement Therapy. Throughout this article I challenge negative, stereotypical views of lesbians at menopause and suggest that listening to lesbians adds a new dimension to the presently narrow, heterosexist and medicalised view of women at midlife.

For many years radical feminists have been warning about the dangers inherent in the use of Hormone Replacement Therapy (Coney, 1993; Klein & Dumble, 1994; Oakley, 1993; Rinzler, 1993; Ussher, 1992; Worcester and Whatley, 2000). Finally, in 2002, results from the Women's Health Initiative (WHI) confirmed their concerns. The US based WHI, the largest ever clinical trial and observational study was designed to assess the risks and benefits of a number of interventions, notably hormone replacement therapy (HRT), to potentially prevent cardiovascular disease, breast cancer, colorectal cancer and osteoporosis in healthy postmenopausal women (Goldman, 2004). According to the Writing Group for the Women's Health Initiative Investigators (2002), the rates of cardiovascular disease events, heart attacks, strokes, blood clots and breast cancer were increased in women taking oestrogen/progestin (combined HRT) compared to those taking the placebo. These adverse results will be discussed later in this article.

This article reports on aspects of a larger study that sought to examine lesbians' experiences of menopause in Australia to highlight how lesbian voices and radical feminist analyses of the medicalisation of midlife are overlooked and dismissed (Kelly, 2004). In the study I challenged negative, stereotypical views of lesbians at menopause and suggested that listening to lesbians adds a new dimension to the presently narrow, heterosexist and medicalised view of women at midlife.

The primary focus of this article is to critically review some of the longstanding feminist critiques of the use of HRT for menopausal women. To support my discussion I draw on the opinions and experiences of lesbians who participated in my study on menopause. I write from the perspective of a radical feminist lesbian researcher and registered nurse and midwife. As I will discuss below, in most discussions about HRT and menopause the perspective of lesbians is omitted. I suggest that this is regrettable as we can learn a great deal of attitudes to HRT and menopause. This article thus asks if lesbians have a different view of the medicalisation of midlife in general and the issue of HRT in particular.

Feminists have been aware and critical of the medicalisation of women's lives for a very long time (Coney, 1993; Crock, Guymer, & Klein, 1999; Klein & Dumble, 1994; Oakley, 1993; Rowland, 1992). It appears that every major stage in a woman's life is now under the watchful eye of the medical 'experts.' Evidence of this medicalisation begins in adolescence where girls and young women aged from 9–26 years

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are now vaccinated with Gardasil, the cervical cancer vaccine. Despite a lack of trial data on girls this age, Australia is providing a fully funded immunisation campaign. A recent editorial in the Journal of the *American Medical Association* stated: "it is important to emphasise that the vaccine is supported by limited efficacy and safety data" (Gostin & De Angelis, 2007, p. 1921). Some medical practitioners even prescribe the "morning after pill" to young women who are not yet sexually active in an attempt to reduce Australia's high teen abortion rate (Dunn, 2003). The medical rationale is to regulate their periods or enable them to engage in heterosexual sex without the risk of pregnancy. However, at the same time, these young women are exposed to sexually transmitted infections and side effects of contraceptives. Later, medicalisation takes place in dangerous and costly infertility treatments to 'assist' infertile heterosexual 'couples' (yet these drugs and treatments are given to only half of the couple and that is women, not men). Further healthy pregnancies and childbirth are now routinely 'monitored' by high technological equipment and invasive procedures. And finally, as women move to mid life, hormone replacement is prescribed to alleviate the 'symptoms' of menopause in perimenopausal as well as postmenopausal women.

With the increasing medicalisation of women's lives comes pressure on women to 'take control' of their health. Nancy Worcester and Mariamne Whatley, (2000) US editors of *Women's Health: Readings in Social, Economic, and Political Issues*, point out how the focus on preventative health care is a shift away from the 'sick care model' to a more individualistic, self-care model where women are targeted as major consumers of the preventative services. Health screening is heavily promoted as the responsible course of action for women to take. Indeed women are made to feel guilty if they do not avail themselves of modern technological 'advances' which cover a wide range of tests, drugs, and medical procedures. Some of these 'advances' aimed at women at midlife and beyond include bone density assessments for the detection of osteoporosis and free 'breast screening' for the early detection of breast cancer, as well as new hormonal preparations to alleviate the distressing 'symptoms' of menopause (Crock et al., 1999). Worcester and Whatley (2000) argue that the successful marketing of hormones to menopausal and postmenopausal women plays on the 'fear factor'. According to these authors, 'fear can become an important selling point for either true prevention or early detection tests' Worcester and Whatley (2000 p. 318). They point out that fear is created not only by conjuring up debilitating diseases but also by playing on women's fear of ageing.

In an ageist and heterosexist society such as ours, women's experiences of growing older are not usually pleasant (Cole & Rothblum, 1990; Copper, 1988). It is, therefore, not surprising that many women will look for ways to delay the effects of ageing. New Zealand feminist, activist and author Sandra Coney, in *The Menopause Industry*, (1993) argues that the success of the HRT campaigns is largely due to society's obsession with the desire for eternal youth and beauty. She explains (1993, p. 163):

> The appeal through the lay media worked on women's fears about ageing. Women were promised the preservation of their youthful appearance; a powerful inducement in a culture that worships feminine sexual attractiveness. The critique of the postmenopausal woman offered by these doctors and repeated in the lay media – the anxious, wrinkled, depressive – hit a nerve in women's psyche. For many women, their 'looks' were their greatest asset.

Many lesbians have long been aware of the role medicine plays in the perpetuation of 'compulsory heterosexuality'. The lesbian feminists who participated in my study clearly rejected the male constructed ideal of beauty. Many participants indicated that a feminist identity provides some protection from the patriarchal standards of femininity.

Research design

For my PhD, I utilised both quantitative and qualitative research methods in order to provide a deeper level of analysis. One hundred and sixteen self identified lesbians completed and returned questionnaires from every Australian state and territory between 2001 and 2002. Participants who returned questionnaires ranged in ages from 39–64 years. I then conducted in-depth interviews with 20 women: 10 face -to-face interviews and 10 telephone interviews. The interviewees ages ranged from 46–60 years. Telephone interviews were conducted in some cases due to interviewees living interstate, and some interviewees requested a telephone rather than face-to -face interview.

Participants were drawn from a range of locations and included a mix of metropolitan and rural locations. Twelve out of 20 identified as feminist and 3 out of 20 were taking HRT at the time of interview. Fourteen out of 20 lesbians I interviewed were in lesbian relationships at the time of completing the questionnaire.

Very early in the data collection phase, common themes began to emerge organically. Lesbians from different parts of Australia were articulating similar issues, which I had not found in the mainstream menopause discourse. Themes were grouped together which enabled me to develop propositions to be further explored in the in-depth interviews. The grouped themes were used to categorise and explore accounts of the respondents' experiences. The emergent themes mirrored and lent themselves to comparison with the themes I identified in the Literature Review. Not surprisingly, Hormone Replacement Therapy was one of the strongest themes which emerged.

When participants from my study are quoted in this article I use pseudonyms and numbers. In order to distinguish between questionnaire and interview responses, I have used pseudonyms to indicate interviewee's responses and numbers to indicate qualitative commentary from the questionnaire responses. In all cases interviewees chose their own pseudonym.

Women's words and insights

Many of the women I interviewed were highly critical of the medicalisation of menopause generally and HRT specifically. "Andy", one of the interviewees, asks:

> We don't give adolescents something to prevent puberty so why would we give something at the other end to prevent that? What it prevents is what the patriarchal society says we are supposed to continue in. We are supposed to stay sexually available to men, our breasts are

> supposed to stay firm. We are supposed to be available for servicing men at any moment and menopause takes us out of that realm. So if they delay or prevent menopause, it keeps us their creatures longer. I don't know, what is HRT supposed to do? Supposed to keep us youthful and appealing, with firm breasts and non-ageing skin? HRT is designed to continue the availability of women to men as men define it and our own natural bodies have times when we are not suited for sexual activity with men, if that's our choice. The availability to men is no longer an issue, because we are now the crones. Now we are menopausal and now is the time when we are available to ourselves.

Unfortunately there is little evidence presently available to show if lesbians internalise these negative fears of ageing, nor do we know whether lesbians, as a social group, feel differently about the use of HRT and other technological 'advances'. However, many lesbians in my study articulated views that are antithetical to the medical model. The majority of women participating in my study acknowledged menopause as simply a stage in a woman's life. Other examples include:

> HRT enables doctors to give something to older women, whatever the health complaint may be. [1]

> HRT puts unacceptable artificial hormones into the body and provides dollars for the industry aiming to medicalise all natural bodily functions. It increases the risk of further illness and cancer but is promoted as preventing heart disease, osteoporosis and symptoms of menopause. It turns women into guinea pigs. [2]

Sandra Coney (1993) writes that the midlife woman is now 'a prime target for the new prevention-orientated general practice' She asserts that the medicalisation of menopause has created a new industry, which enables the general practitioner (GP) to feel 'active, useful and effective'. She explains:

> Research careers are being built around her, and there are doctors and medical entrepreneurs who wish to measure her bones, her breasts, the cells on her cervix and her hormone levels. People build machines that can scan, photograph, X-ray, and magnify the most intimate parts of her body. The pharmaceutical companies have a veritable chocolate box of pills, patches, pessaries, and implants for the midlife woman. She can swallow them, have them sewn into her flesh, or even insert them into her vagina — from where the magic hormones will course through her body transforming everything they touch (p. 15).

Similarly, radical feminist author, academic and activist, Renate Klein (1992), comments that as middle-aged women are diagnosed as 'walking diseases', the medical profession sees there is only one way to avoid 'menopausal misery' and that is to take HRT Klein (1992 p. 24). Despite these and other feminists' criticisms of the medicalisation of menopause, lesbian concerns were rarely addressed. Sandra Coney (1993), acknowledges that the heterosexual community is more restrictive in terms of allowable behaviour than the lesbian community; however, even she does not focus in any detail on lesbians' experiences of menopause.

It is obvious that women's experiences of menopause do not occur in a vacuum. Every facet of a woman's life is multifactorial and influenced by the wider socio-political and cultural contexts in which she lives, and menopause is no exception. Social contexts provide a structure for understanding our complex lives and, as such, it is important that these contexts be acknowledged and understood. In doing so, it is necessary to realise that homosexuality was only declassified as a mental illness in 1973 in the United States. Prior to 1973, lesbians and gay men were looked upon as sick and deviant and, as a result, were subjected to a range of humiliating and harmful interventions in an attempt to 'treat' and 'cure' their homosexuality (Wilton, 1995). It was not until 1992 that the World Health Organisation removed homosexuality from the *International Classification of Diseases*. Fortunately, today homosexuality is no longer officially regarded as a mental illness; however, lesbians and gay men still experience discrimination and prejudice as a result of this earlier biological determinist model of homosexuality.

Hormone Replacement Therapy for menopause has been around for more than half a century in the western world. In 1966 Robert Wilson, a prominent Brooklyn-based gynaecologist, published a book, *Feminine Forever*, that espoused his theories of oestrogen replacement therapy (Wilson, 1966). Wilson regarded menopause as a midlife woman's 'deficiency disease' and argued passionately that it could – and indeed should – be treated with female hormones. Wilson believed that women ceased to be feminine after menopause and therefore became undesirable. He claimed that women who used oestrogen looked and felt better, and he began promoting hormone replacement therapy for women from the premenopausal years until the grave (Lewis, 1993).

Feminine Forever sold more than 100,000 copies in its first seven months, having received much media hype in a diverse range of magazines including *Time* magazine and *Vogue* (Coney, 1993). Ever since the promise of a 'youth pill' through which, according to Robert Wilson in the 1960s, menopause could be avoided and ageing alleviated, women have turned towards HRT in search of the promise of eternal youth. Coney (1993) claims that it is the preoccupation with the restoration of youth, beauty and [hetero]sexual prowess that is responsible for the success of the HRT-awareness campaign. As women in the westernised world can now expect to live at least one third of their life after menopause, they make up a large market of potential HRT consumers. Pharmaceutical companies therefore stand to gain massive financial benefits as a consequence of the ageing female population (Berger, 1999).

Coney claims in a culture that worships 'feminine sexual attractiveness', Wilson's work was accepted and embraced by many women (Coney, 1993). The entire notion of femininity is highly problematic for many feminists. 'Femininity' has often been used to keep women subservient and subordinate to men. Feminist psychologist Dee Graham defines femininity as follows:

> Femininity describes a set of behaviours that please men because they communicate a woman's acceptance of her subordinate status. Thus, feminine behaviours are survival

> strategies. Like hostages who bond to their captors, women bond to men in an attempt to survive, and this is the source of women's strong need for connection with men and of women's love of men (Graham et al., 1994 p. xv).

Many lesbian feminists reject the concept of femininity and as a result might be less likely to pursue behaviours and adopt practices that are regarded by mainstream society as reflecting 'femininity'. The following quote from one of my study illustrates this point:

> HRT provides artificial oestrogen to keep the body younger and sexually available to men. Add progesterone to the recipe to reduce dangerous 'side effects' such as cancer — breast in particular. [3]

If femininity is a concept deemed to be of greater importance and/or relevance to heterosexual women than lesbians, it is possible to surmise that lesbians may be less likely to take HRT. However, despite extensive literature searches, with the exception of one other study by Heather Davis (1993), I was unable to find information that addressed the specific issue of lesbians and their attitudes to, and usage of HRT over the past 50 years.

Menopause as an illness

The biomedical model of health views health as the absence of disease and illness. This model assumes that medical treatment can restore the body to good health (Naidoo & Wills, 2000). In contrast, the World Health Organisation (WHO) defines health as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity' (WHO, 1948). Unfortunately, a great deal of the literature on menopause and HRT reflects the biomedical model of health. Given that the WHO defines health as 'not merely the absence of disease or infirmity', it is interesting that menopause is defined in the following way:

> The permanent cessation of menstruation due to the loss of ovarian follicular activity. Menstruation ceases when the ovaries no longer produce enough oestrogen to stimulate endometrial shedding (WHO cited in NHMRC booklet, 1996, p. 1).

In spite of WHO's acknowledgement of the social and political components of health, the above quote defines menopause as an illness, an oestrogen deficiency disease. Not surprisingly, WHO also promotes oestrogen replacement therapy as the cure (Coney, 1993; Ussher, 1992). By first constructing a disease, a market opportunity is then created for a magic cure. This is not the first time a disease has been constructed and a market for a medical cure created. Female Sexual Dysfunction is another such example. The following quotation published in *Maturitas*, the European menopause journal, highlights this point:

> The gradual deterioration in ovarian function seen during the perimenopause results in a marked reduction in estrogen production and a significant decrease in levels of circulating estrogen. Estrogen replacement therapy (ERT) is designed to increase circulating estrogen levels by replacement hormones, prevent the consequences of long term estrogen deficiency, and treat symptoms associated with the menopause such as hot flushes, night sweats and vaginal atrophy which are a consequence of lower estrogen levels (Palacios, 1999, S2).

ERT as explained in this quote is a cure for these 'symptoms' associated with menopause. Fortunately, this medicalised and disease-oriented view of menopause has been and continues to be heavily criticised. Several of the participants in my study rejected the medicalised and disease-orientated view of menopause. This rejection is evident in the following quotes:

> HRT suspends menopause until such time as HRT stops so it becomes a lifetime prescription unless a woman decides to proceed with her menopause. [4]

> HRT enables doctors to give something to older women, whatever the health complaint may be. [5]

HRT and 'symptom' control

Women are most commonly prescribed HRT for the management of troublesome 'symptoms' of menopause such as hot flushes, night sweats, vaginal dryness and urinary problems.. I use the word 'symptom' in inverted commas, as a symptom is indicative of a disease, which without doubt menopause is not (Moynihan & Cassels, 2005). So strong is the medicalisation of midlife that many people now commonly refer to the 'symptoms' of menopause, therefore constructing it as a disease or illness. This disease focus has arguably had enormous benefits for medical experts and pharmaceutical companies (Moynihan & Cassels, 2005). Similarly we often hear about the 'symptoms' of pregnancy. Women and health professionals alike frequently speak of having a pregnancy 'diagnosed'. This disease orientated view of menopause and other natural stages in women's lives has been, and continues to be, heavily criticised (Coney, 1993; Klein, 1992; Worcester & Whatley, 2000).

It is true that for some women the onset of menopause does bring new or additional challenges and in some cases HRT can indeed alleviate or minimise the distress experienced if taken for a short time. The most common 'symptoms' associated with menopause are hot flushes and night sweats. Australian gynaecologist and first President of the Australian (now Australasian) Menopause Society, Barry Wren, states that 'symptoms' such as hot flushes, sweats, insomnia and a dry vagina are experienced by 40 to 70% of menopausal women (Wren, 1989 p. 35). Other researchers have estimated this figure to be as high as 85% (Hammond, 1989; Rebar & Spitzer, 1987).

Despite the fact that many women experience hot flushes, for most women these hot spells do not cause severe problems and the majority of women do not seek medical attention for them. Many lesbians in my study, although experiencing physiological changes at this time in their lives, did not seek medical intervention. The following quote from

a participant explains why she did not consult a health professional:

> There seems to be an assumption that a 'change' means a 'problem'. I haven't consulted health providers and have discovered that for me, the changes were a stage on the way to menopause. I believe they would've been 'treated' had I seen a health provider and I'm glad that I did not. But I have found very little useful information when I just want information about how common each change is. What I've found when I looked was that the change would be under a heading such as 'problem' and then of course a 'solution'. I didn't want a solution because I didn't think I had a problem, but I would have liked to assure myself that it was NOT a problem [6].

Women who do seek medical attention for hot flushes usually present with multiple issues and might be more likely than women among the general population to seek medical intervention in general (Lock, 1991). It appears obvious that if such a large percentage of midlife women are experiencing similar changes, then rather than reflecting a disease, these changes reflect a 'normal' or usual transition from perimenopause to postmenopause. Unfortunately, however, the biomedical model does not embrace a healthy approach to such changes.

Prior to the release of the Women's Health Initiative findings in 2002, it was also believed that HRT protected women against heart disease, and many women were prescribed HRT for this purpose. HRT is also prescribed to prevent osteoporosis. As I will explain below it is now widely accepted that doctors were wrong in their assumption that heart disease could be prevented with HRT.

The Women's Health Initiative (WHI) and The Million Women Study

The findings from the Women's Health Initiative (WHI) highlight the risks associated with routine use of HRT and challenge previously held beliefs about the benefits of HRT. The US based Women's Health Initiative (WHI) is the largest ever clinical trial and observational study designed to assess the risks and benefits of a number of primary prevention strategies for preventing cardiovascular disease, breast cancer, colorectal cancer and osteoporosis in healthy postmenopausal women. The fifteen-year longitudinal study was launched in 1993 by the National Institutes of Health (NIH) and includes more than 161,000 healthy postmenopausal women aged 50 to 79 years (McGowan & Pottern, 2000). The National Women's Health Network, the only US national membership organisation that is devoted to the health of all women was instrumental in the launch of the WHI. After years of arguing about the need for a large randomised controlled trial (RCT) to examine the effectiveness or otherwise of HRT, the Network considered it to be a major victory when the NIH embarked on such a trial. Archibald Leman Cochrane (1972), medical practitioner and pioneer of the randomised controlled trial, argues that very few medical interventions have been properly evaluated using RCTs. Demand for a cure and/or treatment for a particular medical condition or disease may prevent such trials from being carried out. As a result, some medical treatments are used before they have been shown to be effective — HRT is one such example. It may be argued that other such examples include IVF, RU 486 and Gardasil.

The WHI study findings on the risk of breast cancer in women taking combined Hormone Therapy were published in the July 2002 issue of the *Journal of the American Medical Association* (Writing Group for the Women's Health Initiative Investigators, 2002). The Women's Health Initiative Participant Website summarises the findings as:

> The 2002 report showed that more women taking E+P (estrogen plus progestin) developed breast cancer than those taking placebo (inactive) pills. This updated analysis shows that after an average of 5.6 years, 245 of the 8506 E+P women and 185 of the 8102 women on placebo developed breast cancer. Of the total cancers, 349 cases were invasive, a type of breast cancer with a greater chance of spreading to other parts of the body. The conclusions below are based on the invasive breast cancer group.
> • The increased risk of breast cancer due to E+P was eight additional cases of breast cancer for every 10,000 women over 1 year
> • Overall, there was a 24% increase in the risk for breast cancer due to E+P
> • The breast cancers in the E+P group had similar characteristics to those in the placebo group. However, the tumors in the E+P group tended to be larger and more advanced (had spread to the lymph nodes or elsewhere in the body). A more advanced stage is usually associated with poorer outcome. (www.whi.org/findings).

The participant website further informs women that:

> After even 1 year, quite a few more women had abnormal mammograms in the E+P group (9.4%) compared to the placebo group (5.4%); this pattern continued until the study ended. An abnormal mammogram is a breast X-ray that results in a recommendation for additional medical evaluation (most often, a shorter time between mammograms, but sometimes, a breast biopsy or other tests). Although we have known from other studies that E+P use increases the density of breast tissue on mammograms, the increase in abnormal mammograms with E+P use seen in this study is a new finding (www.whi.org/findings).

The following numbers of women affected relate to the number of women per 10,000 women each year. For example, 37 women per 10,000 women each year taking oestrogen/progestin had a heart attack compared to 30 women per 10,000 women each year taking placebo or dummy pills. Similarly, rates of stroke increased to 29 women per 10,000 women taking oestrogen/progestin compared to 21 women per 10,000 for women taking placebo tablets (Writing Group for the Women's Health Initiative Investigators, 2002 pp. 321–333).

The rate of blood clots was more than double in women taking oestrogen/progestin when compared to those taking placebos (34 women per 10,000 taking oestrogen/progestin had blood clots in the legs or lungs, compared to 16 women per 10,000 taking placebo tablets) In terms of breast cancer, a 26% increase was noted in women taking HRT. That is, 38 women per 10,000 developed breast cancer on oestrogen/progestin, compared to 30 women per 10,000 taking placebo

tablets (Writing Group for the Women's Health Initiative Investigators, 2002 pp. 321–333). The results of the HRT trial confirm the concerns of the Network and show that they were indeed right to be wary of the unsubstantiated claims made by pharmaceutical companies about the supposed benefits of HRT.

A report published in the New England Journal of Medicine revealed that the incidence of breast cancer in women in the United States fell sharply (by 6.7%) in 2003, as compared with the rate in 2002. The authors conclude, "the decrease in breast cancer incidence seems to be temporally related to the first report of the Women's Health Initiative and the ensuing drop of hormone-replacement therapy among women in the United States" (Ravdin et al., 2007, p. 1670).

More recently, the published results of *The Million Women Study* confirm additional risks of HRT. The Million Women Study is a national study of women's health, involving more than one million UK women aged 50 years and over. The main focus of the study relates to the effects of hormone replacement therapy use. Other factors being investigated include diet, childbirth, breastfeeding, vitamin and mineral supplement use, oral contraceptive use and family history of illness (www.millionwomenstudy.org). Results from this study also show an increase in the risk of ovarian cancer in women taking HRT. An article published in the prestigious medical journal, *The Lancet* (May 2007), concluded, "women who use HRT are at an increased risk of both incident and fatal ovarian cancer. Since 1991, use of HRT has resulted in some 1300 additional ovarian cancers and 1000 additional deaths from the malignancy in the UK" (Million Women Study Collaborators, 2007, p. 1703).

Whilst there are still groups and individuals within the medical profession and scientific community who continue to refute the results of the WHI and The Million Women Study, clearly the results have had an impact on both doctors and the women who consult them for information, advice and treatment. Women in Australia are also now being advised not to take HRT for preventative effects as, according to the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (2007), the risks clearly outweigh the benefits, should it be administered long term.

When the media released the results of the WHI, many women who were taking HRT stopped it abruptly. Doctor's surgeries and other health agencies were inundated with phone calls and enquires from women concerned about the study results and the impact on their health and wellbeing. It was reported that most of the 13 million women in the United States taking HRT now questioned if they should continue (Cyr, 2003).

Women's views and experiences of HRT

It is extremely difficult to determine the exact number of women using HRT at any given time. It has been estimated that in the state of Victoria, Australia, in the late 1990s, one in four menopausal women was taking HRT (Vollenhoven, 1999). Diane Palmer, Head of the Menopause Clinic at the Royal Women's Hospital Melbourne, Australia, estimates that HRT is used by 40% of Australian women aged between 45 and 64 years (Palmer, 2002). Sixteen per cent of lesbians in my study were taking HRT at the time of completing the questionnaire in 2001 ($n=19$) (Kelly, 2005). This number appears to be smaller than the figures cited in other, larger studies. It must be noted that the vast majority of questionnaires were completed and returned *prior* to the WHI research findings being released in 2002. Almost 14% of lesbians in my study had previously tried HRT for various durations. Many of these women discontinued its use after a short time. This concurs with the findings of other published studies which show that HRT treatment is frequently abandoned during the first year. Reasons cited for its discontinuation in my study were similar to those cited in other studies by heterosexual women and included concern about the increased risk of cancer, unwillingness to take 'unnatural therapies', unknown long-term side effects, and the fact that for some women, the menopause 'symptoms' persisted despite HRT.

Other lesbians appeared to reflect a philosophical view of menopause and the role of HRT. In an interview, "Elizabeth" a 47-year-old lesbian explained:

> I've always seen it [menopause] as just another life stage and because I see it as a life stage it's just well ... that's just what happens and there will be some inconvenient times and there may be times when you're not feeling very well but you just get on with it. Lots of women I know have gone and sought medical treatment and some are using HRT but they are still experiencing what I would have called 'indicators' of menopause. I played sport for a lot of years and you just play with injuries, so things that are inconvenient, like you still swim if you've got your period, 'coz you can't allow ... or for me, I can't allow issues around menopause or anything like that get in the way of my life. So I guess it's an attitude towards it that ... I guess it's like when people have chemotherapy. They either make a decision that it is going to be horrible, horrible, horrible and they put themselves to bed or they say, 'I have to have this treatment but then I come out and I go back to work and get on with it.'

The mean number of years a lesbian involved in my study had been taking HRT was 4.97. Eight out of 18 participants had been taking HRT for 5 years or longer (two women took HRT for more than 10 years; one woman did not answer this part of the question). Given the later 2002 WHI findings, such long-term use could have serious health implications for these lesbians. Although my research was conducted prior to the release of the WHI findings, controversy over the safety of HRT use was already widely known. Many of the lesbians I interviewed mentioned this controversial issue, yet the 19 lesbians taking HRT in my study all stated they had made informed decisions nevertheless to take HRT.

The Women's Health Australia study data for the Phase 2 survey of the mid-age cohort (47–52 years) found that 23.2% of women were currently taking HRT and 76.8% were not (Women's Health Australia, 2002, 9). The lower numbers of women taking HRT in my study is intriguing. Whilst I realise that mine is not a representative sample of lesbians living in Australia, and for that reason no absolute conclusions can be drawn, I suggest it is an interesting finding that the number of lesbians taking HRT is considerably lower than in other studies with predominantly heterosexual women. Some of my study participants in fact suggested that HRT may be more popular with heterosexual women, and several spoke of

the role HRT plays in perpetuating the role of "compulsory heterosexuality". These comments were reported in both the questionnaires as well as the interviews. Questionnaire responses included:

> I suspect that HRT would be more popular with heterosexual women, maybe because of pressure from their male partner to "get better quickly" but that is just a thought without any basis in reality. [7]

Although this participant stated that this was "just a thought without any basis in reality", it appears that for some women the connection between HRT and heterosexuality is very real. For example, "Merle" wrote that if she were still married she would most likely be taking HRT.

Merle is 50 years of age, identifies herself as postmenopausal and had been in a heterosexual marriage for 20 years. She has two adult children and has recently 'come out' as a lesbian. In the follow-up interview Merle explained:

> Yes, I suppose it is my own personal experience, but when you are with a man you sort of have to come up to a certain standard, and the thing is, he would probably encourage me to do something about it [menopause]. Because if I'm uncomfortable then of course I didn't want sex, and that was a big thing. So he'd be encouraging me to take something to lessen the symptoms to make me more comfortable so I'd be happier sort of … to go along with whatever he wanted, and yet, with another woman I don't feel that at all. It's sort of like it's normal life, if you're a married woman and your kids are growing up, you're going through menopause, you take HRT. Life is different now and I just don't want to go down that track.

Merle's explanation is similar to the view expressed by Germaine Greer. In *The Change* (1991), Greer explains how HRT is given to women to promote marital sex. She cites an earlier study reported in the *British Medical Journal* (Ballinger, 1975) in which only 114 women out of a sample of 539, aged between 40 and 55 years, would discuss sex with the author. In this study, only 40% of the women with poor libido had a good relationship with their husband, compared to 66% of those with unimpaired libido (Ballinger, 1976 pp. 1183–1185). Germaine Greer asserts that these figures are seen to present a case for hormone replacement therapy. She points out that nobody ever asks the woman if her husband is attractive or even a good lover. She writes:

> the wife has already been told how to dress, how to suggest new adventurousness in sex, how oestrogen will make her breasts taut and so forth. Nobody has ever suggested that her problem might be lack of interest. Hers too might be a dull mind, a dull job or a dull husband. Yet people whose minds are not stimulated are likely to have dull minds; housework is a dull job and the kinds of jobs generally done by women outside the home are dull jobs, and husbands can be very dull, especially if their best efforts have already been expended on people they consider more important in their workplace or their playplace. The situation is as unendurable and deadly for a woman as it is for a man and she should not be encouraged to dose herself with steroids rather than put an end to it (Greer, 1991, 359).

Many of my interview participants confirmed Greer's notion of HRT and the role they believe it plays in keeping women sexually available to men. Questionnaire data also showed similar views on this topic, as is evidenced in the following comments:

> HRT provides artificial oestrogen to keep the body younger and sexually available to men. Add progesterone to the recipe to reduce dangerous "side effects" such as cancer — breast in particular. [8]

> HRT may offset symptoms of menopause but I believe menopause is simply delayed. There does seem to be a suggestion in advertising that ageing is delayed, therefore women will be more attractive to men. Taking HRT may turn out to be one of the biggest social drug experiments against women. [9]

Conclusion

The WHI results released in 2002 have confirmed many radical feminists' concerns. Women are undoubtedly confused about the value of HRT and are often persuaded to commence HRT as a result of the media portrayal of its benefits and pressure placed on them by the medical profession. Women are made to feel that taking HRT is the responsible course of action in regard to managing their menopause and life thereafter. Without doubt, the release of the findings from the WHI in July 2002 has had a significant impact on the number of women taking and ceasing HRT. This is not, however, the end of the HRT story. Five years on from the release of the WHI findings, scientists, and other medical experts are still refuting the results and presenting what appears to the general public as compelling arguments for this refusal.

This article has highlighted how studies which have explored women's views and experiences of HRT, have failed to acknowledge sexual orientation as a variable and have assumed heterosexuality. In contrast, the women in my research explore the views, experiences and attitudes towards HRT from lesbians' perspectives. I share the view of Ellen Cole & Esther Rothblum (1991), — who believe that it is only when women are freed from societal pressure to live their lives, that menopause might not be the negative experience that presently it is for many. Findings from my study strongly support the many benefits for numerous lesbian feminists who refuse to comply with male constructed images of womanhood and see through the attempts to change women to this ideal through dangerous and artificial means.

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