Between the red tent and the red haze: Representations of perimenopause

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BETWEEN THE RED TENT AND THE RED HAZE

Representations Of Perimenopause

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Faculty of Community Services, Education and Social Sciences

This Thesis is presented for the degree of Bachelor of Social Science (Honours) of Edith Cowan University

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Perimenopause is a relatively new word in our language. It is found in a variety of texts, from medical literature to popular literature and the Internet. In this thesis, I explore some current representations of perimenopause. To do so, I utilise feminist analyses of representations of premenstrual syndrome and menopause. A feminist theoretical framework guides my methodology and organisation and interpretation of data. My methodology includes an extensive literature review of feminist theorising around premenstrual syndrome and menopause, as well as discourse analysis of textual representations of perimenopause and the use of a reflexive journal as a 'perimenopausal' woman. My analysis reveals four main themes; first, perimenopause is a medically defined condition that needs management; second, perimenopause is confusing and contradictory; third, perimenopause is to be feared; and fourth, perimenopause is a time of rejuvenation. I show that three of these themes are similar to themes found in the discourses of premenstrual syndrome and menopause. The implications of these themes are discussed. I conclude by arguing that perimenopause is a distinct discourse that merits further feminist attention.
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31 October 2005

Sheena Maureen McChlery
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CHAPTER 1  
INTRODUCTION

In 1980, the World Health Organisation (WHO) convened a Scientific Group to review all existing information on menopause, and to make appropriate recommendations (WHO Report, 1996, p.2). At this meeting, new terms were introduced and old terms were re-defined. Thus the word ‘perimenopause’ was officially sanctioned (WHO Report, 1996, p.13). Perimenopause, according to WHO, is the “period immediately prior to the menopause (when the endocrinological, biological and clinical features of approaching menopause commence) and the first year after menopause” (WHO Report, 1996, p.13). Menopause is defined, by this same group, as “the permanent cessation of menstruation resulting from the loss of ovarian follicular activity and which is recognised to have occurred after 12 consecutive months of amenorrhoea” (WHO Report, 1996, p.12).

Perimenopause, as a word, has since found its way into usage in numerous texts and resources. It is used in medical texts, the media, mainstream books and in 218 000 web pages found via the Google web search engine (accessed on 22/04/05). It has also found its way into the health conversations of my peers. However, it is still a relatively new word in our language. In this thesis, I explore some of the current representations of perimenopause and to do so, I utilise feminist analyses of the discourses surrounding menopause and PMS.

My interest in perimenopause originated from a search for information on body image in menopausal women. Various self-help books on menopause corrected my erroneous belief that I was menopausal because of the hot flushes and night sweats that I was experiencing. According to the books, I am, in fact, perimenopausal.
I’m very different to many other women, I think. I’ve been looking forward to menopause for a long time, and perimenopause, for me, signals the arrival of menopause. Menopause brings with it the chance to dispense with the contraception which makes me fat and gives me headaches, dispense with the condoms which never seem to fit perfectly, and hopefully dispense with the sanctimonious tight-lipped remarks from the pious few who can’t understand why I haven’t wanted any children. Yes, it will be a freedom for me. And I can’t wait for it.

One book defines perimenopause as an ‘indefinite’ length of time when a woman experiences hot flushes, night sweats and irregularity in the timing and amount of menstrual flow (Voda, 1997, p.131). Another lay definition is more bold with the time frame: “about ten years in a woman’s life during which her body changes its secretion and processing of the hormones needed for reproduction” (Gittleman, 1998, p.4). Yet another definition says nothing about hot flushes, but claims that perimenopause is “the year or two before, during, and after menstrual cycles end” (Lee, Hanley & Hopkins, 1999, p.4).

The variation in these descriptions of perimenopause and the apparent concern with only the biomedical aspects of perimenopause intrigued me. My view on this time period in my own life was that I would probably experience a couple of fairly unpleasant and somewhat disruptive physiological changes for a few years, and then I would stop menstruating. Whilst I had some knowledge of the milder physical aspects of perimenopause, I was not prepared for the dramatic and seemingly endless lists of “common” problems displayed in the books: “vaginal dryness, stress incontinence, mood swings, joint pain, skin pigmentation, growth of body hair, baldness” and so on (Voda, 1997, p.131). It became apparent to me that unlike menopausal women, perimenopausal women should expect to carry on menstruating (irregularly) but also expect the schizophrenic menopausal storms of rage and depression. We are caught between the red tent of menstruation and the red haze of menopausal ‘madness’.
A friend describes her red haze; it's getting more noticeable as she's getting older. When she becomes angry, she sees a red haze over her vision. When she calms down, the red haze goes away. She says it's the menopause (she's in her fifties). Why would she think that? I ask her whether any of the situations in which she gets the red haze are of her own making. She answers in the negative: “So-and-so did something really stupid, and I just saw this red haze appearing before my eyes again”. Why are we, as women, brainwashed into thinking that our hormones are to blame when we get angry? When men get angry, nobody turns on them and says: “You must be hormonally challenged”.

I searched for feminist literature on perimenopause, and found one article that advised psychotherapists how to “help” perimenopausal women “cope with distress” (Derry, 2004). I did not find any feminist studies on the subject of the current representations of perimenopause and how these representations may compare with PMS and menopause.

Menopause and PMS have been shown to have many commonalities in the ways they have been represented. Greer (1991) and Martin (1992) suggest that they are examples of the way in which women’s bodies have been pathologised. Greer (1991) writes of menopause as being ‘discovered’ as an oestrogen deficiency by a gynaecologist, Wilson, in 1966 (p.18). Martin locates PMS historically, and writes about PMS being constructed as an illness in response to increased participation of women in the paid work force in the mid to late 1970s (Martin, 1992, p.121). Murray (1996) indicates that menstruation has largely been situated within a medical setting in Australia (p.1); medicine is a setting where pathology is emphasised, and thus it is no surprise that the more unusual changes associated with menstruation are regarded as abnormal.

The medicalisation of PMS and menopause has both influenced and maintained “societal definitions of appropriate behaviour for women” (Lee, 1998, p.17). Lee comments that a biomedical explanation for PMS has become the
justification for disregarding or dismissing the existence of adverse individual and collective circumstances for women (Lee, 1998, p. 18). The attribution of women’s depression or anger to ‘that time of the month’ has become more socially acceptable than the acknowledgement of such anger as arising from personal and social inequality (Lee, 1998, p.25). This attribution also reduces the likelihood of appropriate action being taken, and responsibility being accepted (Lee, 1998, p.25).

Other aspects of the medicalisation of PMS and menopause have been emphasised. Coney (1991) suggests that the medicalisation of menopause has enforced negative stereotypes of ageing and sexism (p.54). In both medical and lay literature about menopause, the use of words such as “atrophy”, and “sexual decline” reinforce these images (Coney, 1991, p.65). The repeated use of the word “deficient” in discussions of menopause underpins the image of the midlife woman as inferior and flawed (Coney, 1991, p.65).

Labelling menopause as a disease, and PMS as a syndrome, also has the effect of stripping a woman of individuality and self-resolution (Coney, 1991, p.54). The woman is disempowered, because the solution (should she need one) does not lie within her own capabilities, but rather in what the medical profession has to offer (Coney, 1991, p.54). The routine labelling of menopause and PMS as illnesses also suggests that all women who experience these events are sick, and unable to function properly (Lorber & Moore, 2002, p.10). As well, argue Lorber and Moore (2002), one of the dangers of the medicalisation of both PMS and menopause is the hormonal treatment, which isn’t necessarily the correct solution and which may have poor outcomes (p.86). This treatment may also have little effect (Lee, 1998, p.23).

Women themselves do not always view menopause and PMS in such a negative light. In some cultures, menopause is embraced, and even in Western cultures, many women view menopause as a “non-event” (Richards, Seibold & Davis, 1997, p.83). For some women, menopause is not a marker at all, as they cannot separate it from other life events (Martin, 1992, p.176). The
significance of the above discussion, however, is that since menopause and PMS have been so widely medicalised, with the possibilities of negative effects on women, is perimenopause being similarly medicalised? Do the various current representations of perimenopause have the effect of naming or labelling women, or disempowering them, or even simply treating women as an homogenous group?

This study has significance in that there is no feminist research, as far as I could ascertain, exploring current representations of perimenopause. It is my hope that this study may thus contribute to this area of feminist research.
CHAPTER 2
THEORETICAL FRAMEWORK AND METHODOLOGY

Theoretical Framework

A feminist theoretical framework will guide this thesis. This framework will guide my methodology, and my organisation and interpretation of data (Hauck, 2004, p.7). In my search for relevant feminist theory, I discovered that there is no single theory that neatly fits this topic. Tong (1998) has stated that feminist thought is “kaleidoscopic” (p.280), and that “although it has a beginning, it has no end, and because it has no predetermined end, feminist thought permits each woman to think her own thoughts. Apparently, not the truth, but the truths are setting women free” (p.280). Hesse-Biber and Leckenby (2004) state that feminists may use many tools in order to understand the phenomena being researched (p.209). Therefore, in the same way that many feminist theorists have contributed to discussions of PMS and menopause, I now draw upon their diverse viewpoints.

Rowland and Klein (1992) emphasise the way in which radical feminist theory is woman-centred (p.272). This fits in with Sarantakos’ definition of feminist research, which states that feminist research should be by and for women (Sarantakos, 2004, p.56). This is reflected in my research, in that only a woman can experience perimenopause, and I am a perimenopausal feminist researcher.

Rowland and Klein (1992) also talk about the control (by men or patriarchal institutions) over women’s bodies (p.287). They see radical feminists as focussing on the body as a critical site of oppression for women (Rowland & Klein, 1992, p.287). In the discussion about PMS and menopause, this control is seen in the way in which women are encouraged to use hormonal treatment for constructed illnesses. Women ‘suffering’ from PMS are encouraged to use progestogen, a synthetic form of the hormone progesterone (Lorber & Moore, 2002, p.86). Menopausal women nowadays are encouraged to use oestrogen and progestogen combinations, in order to relieve their physical and emotional
changes, and as a form of prophylaxis against heart disease and osteoporosis (Coney, 1991, p.174). Not only are the risks of hormonal treatment diminished by this encouragement, but women are led to believe that they will contribute greatly to the health of the nation as a whole if they take hormones (Coney, 1991, p.175; Lupton, 1995, p.73).

Thiele (1986) writes about how women do not appear in the provinces of social and political thought, because of ‘magic’ that men use to exclude them (p.31). Paraphrasing Thiele, I suggest that women have ‘magic tricks’ played upon them as far as PMS and menopause are concerned, as well. Two of the ways in which women are made invisible are pseudo-inclusion and alienation (Thiele, 1986, p.33). Pseudo-inclusion occurs when a particular theory appears to consider women, but actually marginalises them, by treating them as abnormal (Thiele, 1986, p.33). The male is seen as normal, and the female example is defined as a ‘special’ case (Thiele, 1986, p.33). PMS and menopause have, arguably, been constructed as illnesses, as a show of taking women’s distress into account, but applying a physical, instead of social label to the illnesses (Markens, 1996, p.48). The pathology of an individual woman’s body is emphasised, rather than the social constructs that may initiate the distress (Markens, 1996, p.47).

The second ‘trick’ is alienation (Thiele, 1986, p.33). Whilst women may be the subjects under discussion, they are viewed through the male lens, which can only lead to a distorted view (Thiele, 1986, p.33). Women thus become invisible (Thiele, 1986, p.33) and their experiences become invalid. This can be shown to be the case with PMS and menopause, as well. Only women experience these two events, but men have done most of the research (Coney, 1991, p.9), although this is changing (Sybylla, 1997, p.213). Women’s experiences have not been extensively documented until fairly recently (Coney, 1991, p.10). Part of my journal, therefore, documents my own experiences of perimenopause.
Butler and Flax are feminists who suggest that women should not be grouped as a single homogenous category (Butler, 1992, p.15; Flax, 1992, p.454). They stress the differences both within and between women, and thus emphasise plurality rather than unity (Butler, 1992, p.15; Flax, 1992, p.454). By categorising all women into one single group, the subordination that we are attempting to dismantle is merely repeated (Butler, 1992, p.15; Flax, 1992, p.454). The medicalisation of PMS and menopause has contributed to a social assumption that all women will suffer badly from PMS, and all women will experience menopause in a similar way. Regarding women as the same, as medicalisation does, simply puts into place another “controlling norm”, against which all women will be measured (Beasley, 1999, p.86). My study explores whether all perimenopausal women are similarly homogenised.

Some feminist theorists have borrowed from Foucault in their use of the word ‘biopower’:

the institutional control of the body in the modern state, through methods of categorisation, measurement, definition and validation. It includes practices in all institutionalised areas of life...which thereby generate specific kinds of knowledge about the body – and so produce specific kinds of bodies (Cranny-Francis, Waring, Stavropoulos, & Kirkby, 2003, p.188).

The use of this biopower constructs “docile bodies”, not only individual ones, but populations of them (Cranny-Francis, et al., 2003, p.189). The justification used (in the cases of PMS and menopause) is that of health, and the way docile bodies are achieved is through self-policing (Lupton, 1995, p.10). There is no violent commandeering of bodies (Sawicki, 1991, p.83), nor are there overt forms of control (Foucault, 1977, p.155). Rather, the individual “turns the gaze upon [herself]” (Lupton, 1995, p.11). In examining herself for “signs of wrongness” (Laws, 1985, p.20), she becomes guilty and repulsed (Lupton, 1995, p.10). Personal transformation is needed in order for the individual to
become a self-improved, self-regulated “subject who is seeking happiness and healthiness” (Lupton, 1995, p.11), as long as these aims are the same as those of the political, social and health institutions (Lupton, 1995, p.12). The official definitions of health are not likely to coincide with those of the individual, whose own definition is based on embodied experience and personal knowledge (Lupton, 1995, p.72). However, an individual cannot afford to follow her own path; the productivity of the nation depends on her health (Lupton, 1995, p.73).

In exploring representations of perimenopause, my feminist theoretical framework is informed by both radical and post-modern feminist theory. In the words of O’Brien: “we must not only develop theory but develop a feminist perspective and a method of enquiry from which such a theory can emerge” (O’Brien, 1981, p.24).
Methodology

In this thesis I work from a qualitative research perspective, using a feminist framework. Qualitative research helps to develop an explanation for or an understanding of a particular social phenomenon (Hancock, 1998, p.2). The phenomenon that I explore is perimenopause. As well, the social context and the perspective of those being researched are important in qualitative research (Angus & Gray, n.d., p.51); this of course is a hallmark of feminist research (Sarantakos, 2004, p.56). I have documented my feelings and perceptions as I gathered my information, in a reflexive journal, thus ensuring that my own perspective is obtained in this research.

My research explores how perimenopausal women are “being known” (Sarantakos, 2004, p.56) in relation to perimenopause in the various texts. I place gender at the centre of my research (Sarantakos, 2004, p.56), because only women can experience perimenopause. As I consider texts that have been written in value-laden and political contexts, my research is both political and value-laden (Sarantakos, 2004, p.56).
Method Of Collection Of Texts


The texts that I have chosen (whilst not every woman’s choice) are articles on perimenopause in medical journals, a women’s magazine, self-help books and articles on the Internet. This choice may not be a complete representation, because contemporary women are informed by a wide variety of sources. However, limitations of time necessitated that I restrict my choice. I have attempted to obtain texts that are conveniently accessible, in the way that many women might seek similar texts.

Women’s magazines are easily accessible to many women. They also play an important role in disseminating information to women (Roy, 2004, p.114). A study performed in the USA found that, for women, the most likely source of information about menopause was women’s magazines (Lyons & Griffin, 2003, Introduction, paragraph 5). Similarly, in the UK, women report that the media, along with social contacts, are their major sources of information about menopause (Lyons & Griffin, 2002, Introduction, paragraph 5).

However, whilst magazines might view themselves as authorities on health, they do not have a consistent definition of health (Roy, 2004, p.94). They also reflect a growing medicalisation of normal hormonal events in women’s lives, such as childbirth and menstruation (Roy, 2004, p.108). I was interested, therefore, to see how magazines might depict perimenopause, however, I found
only one magazine article containing the word perimenopause at the newsagencies.

Self-help books are usually aimed at women, and they are comparatively cheap and easily available (Lyons & Griffin, 2003, Introduction, paragraph 8). They also deal with issues that concern the everyday woman (Lyons & Griffin, 2003, Introduction, paragraph 8). The self-help genre is becoming more popular (Lyons & Griffin, 2003, Introduction, paragraph 8), and thus it is a form of information that I have chosen to use. Some self-help books claim to eschew the biomedical model, seeking instead to inform women about the ‘real’ truth about women’s health matters, such as menopause. Sellman’s book, which seeks to inform women of the ‘truth’ about their hormones, sets out to return empowerment to women (Sellman, 1997, back cover). A cursory reading of Sellman’s self-help book, however, reveals a similar preoccupation with biological, hormonal issues to that in medical journals and women’s magazines. Feminists have criticised self-help books on menopause for this reason, as well as for their homogeneity in assuming that most of their readers will be women who are white, reasonably well educated, middle-class, and who are mothers (Lyons & Griffin, 2000, p.475).

The self-help books in my study were borrowed from my local library. From the plethora of books on the topic, I chose one that appeared to have a medical orientation, and one that appeared to have an alternative orientation. I also chose them because of their covers; this will be illustrated further in Chapter 4.

As I have indicated above, the Internet includes many pages that contain the word perimenopause. I only explored the Internet via one search engine. Whilst much of this information may be unsubstantiated, it is available for anyone to view. The Australian Bureau of Statistics provides figures on the use of the Internet; since 1998, Internet use in the home has increased by more than 100% (ABS, 2001). Whilst the ABS does not give a breakdown of figures on the differences between the sexes regarding Internet use, it does note that men are only “slightly more likely” than women to make use of this resource (ABS,
2001). Use of the Internet does imply privilege, as it is not a cheap resource. However, I defend my inclusion of Internet articles with the ABS information, and with the fact that the two self-help books that I review in this thesis suggest that women turn to the Internet for further information on perimenopause.

A website suggested in one of the self-help books is called “Power Surge”. This site featured the authors of one self-help book as guests, and so I use the interview in this thesis. The other two sites are those of *Oprah* and *Dr Phil*. Both of these media identities have dealt with perimenopause on their websites in different ways. The popularity of the shows “*Oprah*” and “*Dr Phil*” (which are discussed in more detail in Chapter 4) led me to the decision to use extracts from these websites.

Medical information from medical journals is disseminated more widely these days; for example, I had no difficulty in subscribing to the *Lancet* website in order to peruse medical articles. One reason for looking at medical journals is that general practitioners (GPs) (who are often the community’s primary source of medical information) obtain most of their information from medical journal articles (private conversation with GP, 2004). Another reason is that I am central to this study, and medical information has informed me, and my experiences. I am a registered nurse and midwife and I have spent most of my twenty-three years of nursing in women’s health. I have access to current medical journals and I am interested, from a women’s health point of view, in what the articles about perimenopause are saying and also, what they are not saying. The medical articles in my study are from a broad cross-section of medical and allied health journals, with the hope that this will represent a wider view of the subject.
Analysis

In analysing the texts, I use discourse analysis, whilst drawing from my review of the feminist literature.

Literature review

Literature on menopause and PMS ranges from technical medical books, describing the processes and functioning of the female body, to feminist interpretations of the representations of PMS and menopause. One could also add the popular literature here as well; the self-help books, magazines, and the Internet. I have focused on feminist literature, which gives critiques of the medical, historical and cultural views on PMS and menopause. This literature also analyses the ways in which these views have disempowered and controlled women and have encouraged stereotypes. Chapter 3 provides a discussion of the literature that I have reviewed.

Discourse analysis

In analysing these texts I again utilise a diverse range of theorists. Phillips and Hardy (2000) define a discourse as “an interrelated set of texts, and the practices of their production, dissemination and reception, that brings (sic) an object into being” (p.3). These texts do not themselves possess meaning but become meaningful when they connect with other texts (Phillips & Hardy, 2000, p.4). Scott (1979) has also noted this phenomenon; she writes that “discursive fields overlap, influence and compete with one another; they appeal to one another’s “truths” for authority and legitimation” (p.760). My choice of texts, as noted above, can often be interrelated.

Lupton (1992) maintains that discourse analysis critiques the language used in texts, in order to show any significance that may be hidden below the more obvious meanings (p.147). She cites Gross when she says that a text or discourse has particular interests that it needs to serve (Lupton, 1992, p.149).
Lupton (1992) differentiates between textual and contextual dimensions of discourse analysis (p.145). She describes textual dimensions as relating to the use of grammar, metaphor and the content of the text (p.145). Contextual dimensions are described as the processes by which the discourse is produced and received, as well as the particular influences in the whole process (Lupton, 1992, p.145).

For my initial content analysis I draw mostly from Reinharz (1992). Reinharz defines content analysis as the “study of a set of objects (i.e. cultural artefacts) systematically by...interpreting the themes contained in them” (Reinharz, 1992, p.146). She goes on to explain that cultural artefacts can be products of individual, organisational, technological or cultural activities (Reinharz, 1992, p.147). By using feminist research to study these cultural artefacts, we can expose the possible patriarchal and misogynist themes contained therein (Reinharz, 1992, p.147). Furthermore, argues Reinharz (1992), we can observe how these themes have reflected and shaped the norms that prevail in society (p.151). The texts or artefacts that I use have the distinct properties of not being purposely created for my study, and not requiring live respondents to question or observe (Reinharz, 1992, p.147).

Lyons and Griffin (2003), who used discourse analysis in their study of self-help books on menopause, cite Parker (1992) when stating that discourses are “shared patterns of meaning” which organise our symbolic systems, and are “necessary for us to make sense to one another” (Procedure and analytic strategy, paragraph 1). In their approach, the texts were treated as “social processes and practices”, and were studied for their content and their structure (Lyons & Griffin, 2003, Procedure and analytic strategy, paragraph 1). They echoed Lupton (1992), in stating that discourses reflect, as well as construct, “social, economic and political forces” (Lyons & Griffin, 2003, Procedure and analytic strategy, paragraph 1).

My analysis was a manual process. I was influenced by the way in which Lyons and Griffin (2003) had used Parker’s ‘critical textwork’ as their method
of analysis; they had attempted to be sensitive to the language contained in the
texts, and had tried to understand the various meanings within the texts
(Procedure and analytic strategy, paragraph 2). However, Colaizzi, as cited by
Hauck (2004), provided me with a more step-by-step method. I read through
each text several times, in order to gain a complete sense of the texts. I wrote
down words, phrases or statements that corresponded with the themes that I
found while reviewing feminist literature on PMS and menopause. I then
grouped the words, phrases and statements into categories, under the headings
of the themes. As will be seen, some of the texts did not contain all of the
themes, and some texts contained a different theme. An exhaustive description
is in Chapter 5.

Reflexive journal

Lupton (1992) asserts that discourse analysis also places an emphasis on the
reception of these discourses by the audience (p.145). For the purposes of this
thesis, I am the ‘audience’. As previously indicated, I am a perimenopausal
woman, and as I have read the texts, I have noted my thoughts and feelings.
Martin (1992) suggested some questions for her exploration of reproduction
(p.22); I have appropriated these questions for use in my reflexive journal.
How do I react to my circumstances (of being a perimenopausal woman)? Do I
describe my existence in the terms used by medical science and dominant
society? If so, do I find these terms acceptable and unquestionable, or do I
lament them, but consider them to be unchangeable? Or am I outraged and
intolerant of them? Do I have an alternate vision of myself as a perimenopausal
woman? Or is my view simply a reflection of the dominant cultural view?

My reflexive journal has kept me ‘on track’ as I have reflected on the effects
that the various texts have had on me. It has been an important part of my
study, as I have used it to add credibility to the way in which I have engaged
with the material. By including my reflexive journal in my research, I am
effectively making visible my private thoughts, and validating my experiences
(Weatherill, 1996, p.4). My perspective is one of an “insider”, rather than an
“outsider”, and this perspective has been critical in my interpretation of the texts (Hesse-Biber & Leckenby, 2004, p.219).

The reflexive journal is not only another form of information, but it also contributes to rigour by providing a “completeness” of the data (McDonnell, Jones & Read, 2000, p.387). Whilst I cannot assume that my thoughts and experiences (as described in the journal) are representative of the thoughts and experiences of other perimenopausal women, the journal contributes to the credibility of this thesis in that other perimenopausal women may be able to recognise similarities (Hauck, 2004, p.2). I have inserted excerpts from my journal in text boxes throughout the thesis.
CHAPTER 3

LITERATURE REVIEW

In exploring some of the constructions around menopause and PMS, various writers used different forms of texts to gather their information, and also highlighted different issues. I will now discuss some of the writers and their literature, and detail some of the issues that they raised.

Premenstrual Syndrome

Markens (1996) writes from a sociological perspective in her piece on “A Political and Cultural Critique of PMS” (p.42). In considering how PMS has become constructed as a disease, she looked at popular magazines and self-help books, and her conclusions have similarities to those of Lee (1998), a psychologist who investigated medical texts written about PMS. Markens and Lee both note that there is no medically proven cause for PMS (Markens, 1996, p.43; Lee, 1998, p.18). However, the focus on entirely physiological processes “encourages the definition of PMS as a medical problem and emphasises the pathology of women’s bodies” (Markens, 1996, p.47). A woman’s distress, rather than being understood in more socially constructed intricate ways, is merely explained in terms of her hormones (Lee, 1998, p.24). The distress, anger and frustration is not only discounted, it is invalidated (Laws, 1985, p.22). It is the woman (or her hormones) who is malfunctioning; society is not to blame (Martin, 1992, p.123).

Lee and Markens also comment on the way in which the experiences of the woman are centred on the individual, whilst social factors, which may contribute to these experiences, are usually disregarded (Markens, 1996, p.44; Lee, 1998, p.18). Structural factors, such as the way in which some women have both a paid job, and an unpaid one (in the home), which may contribute to the stress, anger and fatigue experienced by many women, are not included in many medical and media discussions about PMS (Markens, 1996, p.48).
Markens (1996) maintains, however, that some women have actively participated in the medical construction of PMS as a disease (p.43). Markens (1996) states that the stories that women tell about their experiences of PMS are used alongside articles of medical "expertise", in order to confirm the existence of PMS as a "real" problem (p.48). Women's cures or remedies for PMS also validate the existence of PMS as a bona fide syndrome (Markens, 1996, p.50). Laws (1985), writing from a women's health perspective, issues a similar message:

We should think about the consequences of defining a large proportion of otherwise well women as ill because of unpleasant feelings during part of their menstrual cycle. To assert the reality of these feelings – yes, this is essential – but to decide that they are abnormal and to be stamped out...that is another matter (p.36).

Laws (1985) has documented the historical creation of PMS. She states that PMS as a condition was first coined by Frank, in about 1931 (Laws, 1985, p.26). According to Laws (1985), this doctor suggested that women needed removal of their ovaries or sterilisation, in order to be cured (p.26). After the 1930s, the focus of PMS shifted to women who were considered perverted, for example, female mental patients and prisoners (Laws, 1985, p.46). Laws (1985) notes that two doctors published an article on PMS in 1954, extolling the effectiveness of hormonal treatment for PMS (p.46). Since that time, the treatments prescribed for PMS have varied considerably, and have included antidepressants, vitamins, contraception pills, orgasm, diet control, amphetamines, anti-inflammatories, and "hiding in your room" (Laws, 1985, p.46).

Martin (1992) interviewed many women and also looked at medical texts, in her analysis of PMS and menopause. She claims that interest in menstruation and PMS arose each time women appeared to be gaining some ground in equality (Martin 1992, p.120). Martin notes that in the nineteenth century,
when menstruation was first viewed as being an illness, doctors strenuously declared any work outside the home dangerous for women (Martin, 1992, p.115). The fear of death, literally, for ignoring this advice, was instilled in women (Martin, 1992, p.115). After World Wars One and Two, the advances that women had made in the paid work force were eradicated by negative portrayals of menstruating and pre-menstrual women as being forgetful, inefficient, and lacking in concentration (Martin, 1992, p.121). In the mid to late 1970s, renewed interest in PMS arose. The second wave of feminism and growth in job opportunities for women, amongst other things, contributed to yet another great incursion into the paid work force by women (Martin, 1992, p.121). Martin (1992) argues that these increased participations in the work force by women were seen as threats to the culturally constructed definitions of a woman’s place in society; thus, new tactics were required in order to keep women in the home (p.121).

The portrayal of both PMS and menstruation is overwhelmingly negative, not only in the medical literature (Lee, 1998, p.17; Martin, 1992, p.113), but also in the lay literature (Markens, 1996, p.46). In fact, there is very little information on normal, non-troublesome aspects of menstruation (Lee, 1998, p.21). Laws states that women do not have “times of normality followed by times of illness...; the menstrual cycle is a continuum” (Laws, 1985, p.57). However, the encouragement of women to look for medical advice for their menstrual changes promotes the expectation of ill or diseased bodies (Lorber & Moore, 2002, p.74). The multiple pre-menstrual hormonal changes and their resultant effects on the body have become known as “symptoms” (Lorber & Moore, 2002, p.77), of which there is a list of about one hundred and fifty (Laws, 1985, p.37).

Feminists have debated the reasons why PMS has been represented in these ways. Women are considered deficient when measured against men (Lupton, 1995, p.8). But they are also deficient if they do not meet the patriarchal measures of the normal female role (Lorber & Moore, 2002, p.74). The PMS
“symptoms” which most seem to concern the medical profession are the emotional ones, such as depression and anger (Lorber & Moore, 2002, p. 77; Martin, 1992, p. 130). These symptoms are not consistent with the proper role of a woman in society; she should be nurturing, gentle, controlled, and loving. An angry woman is out of control, and she destroys the harmony of the setting, be it the home, relationship or work (Martin, 1992, p. 130). It has also been claimed that an angry woman may affect a man’s work performance or his emotional control (Martin, 1992, p. 131). This disruption of the normal social order is undoubtedly the responsibility of the woman (Martin, 1992, p. 131), and she needs to be contained (Lorber & Moore, 2002, p. 76).

Lorber and Moore (2002) conclude that the common physiological changes that accompany menstruation have been “medically and culturally interpreted” (p. 72), so as to disparage women, labelling them as incapacitated and inept. They claim that the biomedical perspective on PMS has been socially constructed in an attempt to reinforce the importance of order and uniformity (Lorber & Moore, 2002, p. 73). Laws (1985) agrees, and goes on to state that through PMS, women are encouraged to pit themselves not only against other women, but also against themselves, as they search for signs of “wrongness and disease” (p. 20) within themselves. They have been taught to hate their bodies, because of the negative medical descriptions of their menstrual processes (Laws, 1985, p. 20). The medical framework is the only one in which many women have gained knowledge about their menstrual processes (Murray, 1996, p. 1). In fact, negative portrayal of the menstrual cycle neatly controls women throughout their lives; PMS for women who menstruate, menopause for women over 50, pregnancy for pregnant women, fluctuating hormones of adolescence for teenage women, and specific anomalies for those women who do not ovulate (Laws, 1985, p. 23).
Menopause

Greer (1991) and Coney (1991) are perhaps two of the most cited authors with regard to feminist interpretations of menopause. Greer (1991) used historical texts, literature, medical articles and conversations with women to obtain information about menopause. Coney (1991) examined medical documents to gain an understanding of how menopause has been appropriated by the medical establishment.

De Gardanne was the first person to describe menopause, when he detailed a syndrome he called “la Menespausie” in 1816 (Greer, 1991, p.25). It was then defined in 1899, in an article on ‘Epochal Insanities’. The author of the article, Dr Clouston, described a set of symptoms and thus identified a syndrome that, according to him, needed treatment (Greer, 1991, p.25). The notion that this important process in female development may best be dealt with by women, was not considered (Greer, 1991, p.25). The idea that menopause was a problem came from the viewpoint that (as previously noted) women, when measured against men, were abnormal (Lupton, 1995, p.8). The womb was seen as the real cause for women’s anger, an anger that had its basis in the patriarchal injustices of the time period (Greer, 1991, p.2). Greer (1991) states that the internalisation of this anger by women produced an array of psychosomatic complaints, many of which were dealt with by invasive, but, sadly, non-therapeutic procedures (p.2).

By the 1960s, menopause was being treated as a psychiatric disease, known as ‘involutional melancholia’ (Coney, 1991, p.56). The standard treatment was the use of tranquillisers and antidepressants (Coney, 1991, p.56). Medical journals of the 1960s abounded with advertisements for these chemical products, and the midlife woman was the major target of the advertisements (Coney, 1991, p.56). Coney (1991) attests that part of the reason for this “widespread malaise” was the propagandist articles in women’s magazines (p.57). Women were led to believe that their happiness and fulfilment lay in
their role of housewife, and that they should not have any expectations beyond their front garden gate (Coney, 1991, p.57).

Medical and pharmaceutical establishments referred to the dissatisfaction and anger experienced by many women as a ‘midlife depression’ (Coney, 1991, p.57). This stereotype of menopause as a mental illness was drawn from the work of psychoanalytical writers such as Freud and Deutsch, who described the menopause as a negative time period for women (Coney, 1991, p.57). Women were in crisis at this time, according to the psychoanalysts; they were mourning the loss of their childbearing years and dreading the end of their “feminine attractiveness” (Coney, 1991, p.57). According to Coney (1991), the psychoanalyst Benedek invented terms such as ‘midlife crisis’ and ‘empty-nest syndrome’ (p.57). Benedek stated that if a woman did not succeed in adapting to her prescribed feminine role, she would fail at adapting to menopause as well, a condition known as a “regressive biological process” (Coney, 1991, p.57). This analysis, that women’s self-esteem was totally related to her feminine role in life, was completely accepted in the medical literature (Coney, 1991, p.58).

From the late 1960s, menopause began to be known as a deficiency disease, a physical problem that required treatment with hormones (Coney, 1991, p.59). Coney (1991) details how Wilson, the gynaecologist, had been made aware of a synthetic oestrogen preparation (p.59). Knowing that the ovaries stop producing oestradial (a type of oestrogen) in about the fifth decade of a woman’s life, Wilson quickly changed the menopause-as-a-psychological disease, to menopause-as-a-physical-deficiency disease (Coney, 1991, p.59). In fact, Wilson advocated the use of oestrogen from a woman’s puberty to her death (Coney, 1991, p.59). Coney (1991) cites Wilson as stating that menopause was a kind of “living decay”, a “tragedy” which often destroyed a woman’s “character as well as her health” (p.59).

Thus, menopause has become a metaphor for not only degeneration (Martin, 1992, p.51), but for ageing as well. Coney (1991) asserts that many conditions
that might be attributed to normal ageing are 'dumped' into the same category as menopause (p.81). Osteoporosis is one example. A reduction in bone density can begin in the mid thirties in both men and women; this may be some 15 years before a woman starts to experience menopausal signs (Coney, 1991, p.113). Nevertheless, osteoporosis has become a disease to be linked with menopause, because the body's production of one of the oestrogens (oestradiol) necessary for the maintenance of dense bones ceases at menopause (Coney, 1991, p.114).

Like PMS, menopause is a metaphor for loss of control. Martin (1992) describes how menopause is viewed as a breakdown in the system: “the ovaries fail to respond, and the consequence is decline, regression and decay” (p.173). The resulting unpredictability causes fear, in both men and women, that women will go “insane”, “berserk” or “whacko” (Martin, 1992, p.174).

Spender (1985) was one of the first feminists to write about the patriarchal way in which language is used to demean, disempower and label women (p.139). Martin (1992) has shown how the language in which menopause is described, leads to images of disintegration, deterioration and loss of function (p.44). Coney (1991) has written at length about the supposedly neutral and scientific language used by the medical establishment in describing aspects of menopause (p.65). She gives an example from the book Menopause, written by Llewellyn-Jones and Abraham (1988): “Slowly the vulva shrivels becoming a narrow dry slit in some old women” (p.13).

In a present-day example, Novartis is one company that produces hormone replacement therapy (HRT) in Australia, and sponsors a leaflet entitled ‘Menopause’ (Novartis, 2002), which is prominently displayed and freely available at chemists. The signs and symptoms listed on the leaflet include “dryness... in the vagina”, “loss of confidence, ... crying a lot, reduced interest in sex” and so on (Novartis, 2002). “Risks” of menopause include “thinning of the bones and, later, breaks”, and “sagging of the uterus and/or vagina and, later, prolapse” (Novartis, 2002). The implication that these terrible physical
problems will happen to all menopausal women, instead of an unfortunate few, is great. The leaflet does not mention that these signs may also be found in women who are not menopausal, nor that the signs may well be attributed to reasons other than the menopause, such as poor diet (Greer, 1991, p.150) or social circumstances (Lee, 1998, p.48). The leaflet also fails to mention any risks of HRT.

Lyons and Griffin (2003) discursively analysed the ways in which menopause was represented in self-help books. They noted that menopause was viewed in five ways, namely, as a disease, as natural, as confusing, as ‘the change’, and finally, as a condition to be managed (Lyons & Griffin, 2003, Analysis). They comment that there was a tension between the main discourses of disease and natural in the texts, but that the ‘menopause as confusing’ discourse levelled out any inconsistencies (Lyons & Griffin, 2003, Analysis). The ‘management’ discourse reinforced the view of the doctor as expert, but also managed to imply that the individual woman was responsible for her management as well (Lyons & Griffin, 2003, Analysis).

Gullette (1997) enlarges on the way in which menopause is written about, in her article entitled “Menopause as Magic Marker”. She states that in 1992-1993, “daily press stories, women’s magazine articles, talk-show discussions, major magazine essays, two books for popular consumption”, (both best-sellers), “merging and overlapping and reinforcing at the overlaps” made menopause public and famous yet again (Gullette, 1997, p.176). She names this time the menoboom, and claims that the aim was to reinforce the “cultural consolidation” (Gullette, 1997, p.177) of menopause as a marker in the Before and After of women’s lives. The youthful, reproductive years are the Before, and the declining, ageing years are the After. The reason for this menoboom, writes Gullette (1997), was to reinforce disparity in the [American] world, where midlife women were becoming more powerful, more educated, more financially successful, and more ambitious (p.179). The disparity was that even
in the late twentieth century (at the time of Gullette’s piece), “only women age” (Gullette, 1997, p.179).

Perhaps, then, a reconsolidation of the menopausal discourse requires the addition of yet another discourse. Has perimenopause become the new discourse in the “age-graded” (Gullette, 1997, p.176) reductive discussions about the midlife of women? Is the word perimenopause being used as a backlash against the increased power, education, financial success and ambition that more women are realising? I turn now to some current representations of perimenopause, exploring them with these questions in mind.
CHAPTER 4
THE TEXTS

This chapter constitutes a description of my chosen texts. The chapter will consist of a description of each of the nine texts from three categories, namely, popular literature, the Internet, and medical and allied health literature. Each text will be addressed in turn, as I describe the type of text and its contents. A more detailed discursive analysis of four themes, found in all three categories of the texts, will be presented in the next chapter. The appendices contain copies of the texts and their contents lists.
First Category: Popular Literature

Text One: Self-Help Book


*Could it be...Perimenopause?* is a mainstream self-help book, aimed at women in the so-called perimenopausal age group, as indicated on the front cover: “How women 35-50 can overcome forgetfulness, mood swings, insomnia, weight gain, sexual dysfunction, and other telltale signs of hormonal imbalance” (bold in the original). The authors, Goldstein and Ashner, write specifically for perimenopausal women, directing the wording purposefully: “You are entering a stage known as perimenopause, which begins about a decade before the onset of actual menopause” (Goldstein & Ashner, 1998, p.6) The cover of the book (see Figure 1) shows a comic-type drawing of a woman with blond hair and blue eyes. She also has bright red lips. She has her hands to her face, and appears to be alarmed or confused. It is she who appears to be uttering the words “Could it be...perimenopause?”

*Figure 1. Front cover of the self-help book* *Could it be...perimenopause?*
The dumb blonde! This portrayal both annoys and humours me. I showed the cover of the book to a work colleague the other day; she was showing some interest in my research. Secretly I was interested in gauging her reaction to the picture. I was astonished when she merely remarked that she wanted to borrow the book from me, so as to improve her knowledge of perimenopause. How could she possibly ignore the front cover? Having read the book, I feel that the cover is a good way to judge its contents.

Despite the cover of the book naming two authors, the text of the book is written in the singular. The text refers to a medical “practice”, giving the impression that it has actually been written by the doctor.

Ashner is an internationally published writer, teacher and psychotherapist, according to the dust cover of the book. She also apparently spent “hours” talking to Goldstein’s patients. Yet her work is unacknowledged in the pages of the book. Is she just a token figure – a female to draw in female readers?

Thiele (1986) talks about the invisibility of women by way of exclusion, where women are ignored in a male-dominated environment (p.31). In this text, Ashner is acknowledged as an author on the front cover, yet “magically” (Thiele, 1986, p.32) disappears from the words within the text.

Goldstein and Ashner supply the reader with scenarios, presumably with which the reader may identify, of women who have experienced the “telltale signs of hormonal imbalance” (front cover). The information in the chapters ranges from the “subtle symptoms” (p.9) of perimenopause, to avoiding unnecessary surgery, to recognising menopause “when you get there” (p.172). There is also a chapter on Internet support, and the final chapter is in the form of a pep talk, where Goldstein and Ashner encourage women to seek information, be positive and to live a full life. A full list of contents is attached in Appendix A.
Text Two: Self-Help Book


*The Hormone Survival Guide for Perimenopause* is also a mainstream self-help book, aimed directly at women in perimenopause. Its cover (see Figure 2) indicates: “Balance Your Hormones Naturally: Your Personalized (sic) Prescription for Balancing Mood, Relieving Stress, Alleviating Menopause symptoms, and Losing Body Fat Based on Your Individual Hormone Profile” (bold in original).

The book cover shows a picture of a smiling Jackson, with a stethoscope around her neck. The back of the book cover states that Jackson is a “radio and TV personality, author, national lecturer, spokesperson, and women’s health advocate” (but doesn’t explain the stethoscope).

**Figure 2. Front cover of the book The Hormone Survival Guide for Perimenopause.**

To me, a stethoscope indicates a person with some kind of medical background. As Jackson’s book cover gave no clue as to why Jackson should wear a stethoscope, I searched further on the website www.HormoneSurvival.com which was provided on the back cover of the book. Jackson’s website explains that Jackson is a nurse practitioner, who has a practice “dedicated to hormonal health”.

Journal extract.
The book begins with how it can “help” the perimenopausal woman (p.xv). Jackson states very clearly that current medical logic has fallen short of correctly caring for perimenopausal women. She goes on to explain the variation in hormonal levels that may occur in perimenopause, and the disadvantages of these fluctuations. Tables and graphs make the text easier to understand. After emphasising the importance of hormone testing, Jackson discusses the differences between natural and synthetic hormones, and the various forms that hormone treatment may take. Jackson is quick to state, however, that not all women need to take hormones (either natural or synthetic) in order to reduce some of the unpleasant signs of perimenopause. Diet, exercise and a reduction in stress go a long way to relieving symptoms, according to Jackson.

A chapter on PMS is also included, as well as chapters on libido, thyroid dysfunction and common signs of perimenopause. The final short chapter encourages women to follow a twelve-week plan to “overhaul” (Jackson, 2004, p.142) their hormonal imbalances (with the help of a medical provider) as well as their diets. There are various appendices, listing resources such as compounding pharmacies and weight-loss supplements. Jackson provides a website where information on all of these products may be obtained. Appendix B gives complete details of the contents in Jackson’s book.

**Text Three: Women’s Magazine**


*Good Medicine* is an Australian mainstream magazine, readily available at most newsagencies. The magazine advertises itself as a “personal life coach” (front cover) for the reader and appears to be aimed at women, judging by the pictures, the article content and the advertisements. This article, “Facts and fiction about menopause” (Appendix C), is aimed at the midlife woman who is experiencing hormonal changes prior to menopause. In spite of the title, the
article actually discusses perimenopausal changes, rather than menopausal ones: “it’s the lead-up to it, a stage called perimenopause, that we hear most about” (p.46). The article lists eight common ‘myths’ and then attempts to debunk them, by “[separating] the fact from the fiction” (p.46). Examples of some of the myths are: “All women experience symptoms such as hot flushes”, and “Women lose their sex drive” (p.46). With the help of a director of the Jean Hailes Foundation, “a clinical and research organisation dedicated to women’s health” (p.46), the reason for the origin of the myths is given, and then followed by the “facts” (p.46). All but one of the myths deals with physical changes; depression is the only emotional or psychological issue that is mentioned.

This article claims to debunk the myths, but I feel depressed just reading about them all! It also leaves me with questions, such as: why mention some of these myths at all? I find it difficult to believe that women may automatically link weight gain and hysterectomy with either menopause or perimenopause. 

Journal extract.

The Oprah Winfrey Show is the number one talk show in the USA, and has been so for nineteen consecutive seasons, according to Oprah’s website (www.oprah.com). The show is watched by forty-nine million viewers a week in the USA, and is broadcast in 117 countries, including Australia (www.oprah.com). The website features highlights from the talk show, as well as articles from Oprah’s magazine ‘*O, the Oprah Magazine*’. This article (Appendix D) is taken from the website, but it originally featured in the August 2002 issue of the magazine. The article is entitled “*Be Aware, Be Very Aware*”, and subtitled “*Oprah’s Own Story*”. It is aimed directly at women: “Before you declare yourself perimenopausal...” (www.oprah.com/health/omag/health_omag_200208_menopause.jhtml, emphasis added).

Oprah tells the story of how she awoke one day with palpitations. She was terrified by this occurrence and consulted five different doctors in an attempt to discover the cause. None of them could explain the reason for her palpitations. Finally, her trainer mentioned menopause to her. Denying that she could be menopausal, Oprah then experienced a “miracle” (www.oprah.com/health/omag/health_omag_200208_menopause.jhtml); she discovered Northrup’s book “*The Wisdom of Menopause*” (2001) and read signs in the book similar to those she had been experiencing. She contacted Northrup, and the rest of the article deals with information from the book and from Northrup herself.

Dr Phil McGraw hosts a daytime talk show on television. Oprah’s production company created the show in 2002 (www.oprah.com). It consistently ranks second amongst all the United States talk shows (www.oprah.com). In Australia, an average audience of 297 000 watches Dr Phil from Monday to Friday, with 76% of that audience being female (personal communication, 23/09/05). Dr Phil, a certified psychologist, deals with “topics ranging from human functioning to behavioural medicine to legal issues” on his shows (www.drphil.com).

In my mini-survey of colleagues at work, I discover that I am in the minority when it comes to watching Dr Phil. I hadn’t even heard of him until recently. As part of my ‘research’, therefore, I felt obliged to view one of his shows. He is certainly an engaging fellow, but the American dramatics irritated me. It’s a good job Dr Phil doesn’t have to rely on me to boost his numbers.

The piece that I analyse here (Appendix E) is part of a program entitled “Hormones From Hell”, which consisted of people being interviewed about different aspects of perimenopause. Dr Phil interviews Gittleman, the author of the book “Before the Change: Taking charge of your perimenopause” (1998); Dr Phil’s wife, Robin, is also on the show. Robin persuaded Dr Phil to do the interview, after reading Gittleman’s book, and applying the principles to her own life. The interview begins with Dr Phil praising the book and asking Gittleman to explain her “peri zappers”; these are tools and techniques “designed to zap the symptoms of perimenopause”. Dr Phil adds a comment here and there, and Robin endorses Gittleman’s methods, by saying that she feels “a healthier person at 50 than I was at 40".
Text Six: Website - Power Surge


The website, http://www.power-surge.com/*, is one of a number of sites mentioned in text one. The website is hosted by Alice Stamm, who gives herself the alias of ‘Dearest’. On the section of the site known as Power Surge Live, ‘Dearest’ hosts live guests, who talk about their topics of expertise, and answer questions from the general public. Two such guests on this website were Goldstein and Ashner, the authors of text one, and the transcript that I analyse (Appendix F) is comprised of this particular interview.

After introducing the two guests, ‘Dearest’ briefly explains the content of the book, with the authors providing some information as well. Thereafter, the authors answer many questions from ‘callers’ to the site. As can be seen from the transcript, each person asking a question has a call-name, so that there is no way of identifying the caller’s gender. All of the questions, however, pertain to physiological changes in the body during perimenopause, problems encountered with various treatments, and what kinds of treatment to use, thus implying that all of the callers are not only female, but may also consider themselves to be perimenopausal.

Whose neck do I feel like ringing the most? Is it Dearest’s neck, or her guests’? I feel that patronising feeling enveloping me again. Do women really dwell on all of these perimenopausal effects, and if so, why do they use this medium to discuss them? Maybe because Goldstein is possibly a famous personality in the USA. But where are their peers, their mums, their friends? Do all of these women rely on the ‘net for other forms of information as well?

Note to self: must check out more chat rooms. Journal extract.
Third Category: Medical / Allied Health Articles

Text Seven: Medical Journal


This journal is aimed at the medical industry, specifically those who work in obstetrics and gynaecology. It is divided into two sections; one section discusses an obstetrics issue and the other discusses a gynaecology issue. The entire gynaecology section in this journal is focussed on perimenopause. There are ten articles in this section, all written by doctors from different perspectives of medicine. I have chosen the article by Nachtigall (Appendix G), because, co-incidentally, she is the doctor who provided the foreword to text one.

Nachtigall begins by noting how very little has been written about perimenopause. Her hope, as expressed in the second paragraph, is that this will change, so that the “quality of life” (p.921) of perimenopausal women can improve. After discussing some of the physiological aspects of perimenopause, Nachtigall then enlarges on each of the five major categories of symptoms that she has listed (p.923). According to Nachtigall, the most common symptom is a change in menstrual pattern.

> Accustomed as I am to reading medical articles, I am looking at this one from a feminist perspective. And it really is depressing in its depiction of perimenopause. No wonder doctors view perimenopausal women as sick, if this is all they have to go on. Interestingly, though, this article strikes a chord with me. Quality of life is a definite issue for me in perimenopause. Hot flushes, formication, irregular periods – all impinge on my daily existence. I feel embarrassed and annoyed by their control over my usual activities.

Journal extract.
Text Eight: Allied Health Journal


This journal is aimed at those who work in the health industry. The article that I analyse (Appendix H) begins by talking about menopause, and how yoga may help women who are looking for a “natural and healthy transition” (p.169). The author goes on to discuss how various yoga postures and exercises, meditation, and relaxation can be beneficial for ‘transitional’ women. The article vacillates between talking about menopause and perimenopause, without defining the differences between the two. Included in the article are pictures of six yoga poses, with explanations as to how each pose may benefit one’s body.

Does Khalsa really think I’m going to be able to get into some of these positions, now that I’m perimenopausal? I don’t think so! And why should perimenopausal or menopausal women be picked upon for rejuvenation? It annoys me that many of the ‘changes’ that women are advised to make during these ‘transitional’ years are common-sense adjustments. Paying special attention to my body’s needs should be an ongoing phenomenon, not something particular to this time of life.

Journal extract.

Text Nine: Allied Health Journal


This journal is aimed at those who work in, or have an interest in, obstetric, gynaecological and neonatal nursing. McVeigh conducted a quantitative survey at women’s health centres in New South Wales, in order to identify “the most common perimenopausal symptoms”, and to “explore the extent to which these symptoms were distressing” (p.21). Her findings contradict other medical
McVeigh cites Nachtigall (see text seven), in stating that changes in menstruation and hot flushes are the most common symptoms of perimenopause. However, McVeigh found that women identified forgetfulness, lack of energy, irritability, poor concentration and weight gain as the most common symptoms, with the most distressing symptom being weight gain (p.25). Appendix I contains the journal article.

I don't know the WHAS; I wonder if the women named the symptoms themselves, or whether the WHAS named the symptoms. Funnily enough, I concur with Nachtigall's claims.

This chapter has outlined the texts that I use to find representations of perimenopause. The following chapter will discuss four of the most common themes that I have found across the three categories of texts.
CHAPTER 5
ANALYSIS AND DISCUSSION

This chapter details four themes that I perceive to be prominent in all of the texts. This analysis is necessarily subjective, as it relies solely on my reading of the texts (Lupton, 1992, p.148). However, I include many extracts from the texts, so that the reader can validate the conclusions I reach (Lupton, 1992, p.148). In undertaking the analysis, I used the steps as described in my methodology (Colaizzi, as cited by Hauck, 2004).

1. **Perimenopause is a medically defined condition needing management**

Each text alludes, in some way, to the view that perimenopause is a medically defined condition that needs some form of management. This theme is, in fact, the dominant theme across all texts, despite texts two and eight promoting a ‘natural’ stance. Lyons and Griffin (2003), in their exploration of self-help books on menopause, separated the themes of disease and management. I suggest that here they belong together, because wherever the pathology of perimenopause is mentioned in the texts, ways of dealing with this pathology are quickly suggested. I have also emulated Lyons and Griffin (2003) in using the word ‘management’, rather than ‘treatment’, as there are no startling claims of ‘cure’ for perimenopause in any of the texts. This is in contrast to the claims about the curative aspects of oestrogen for menopause (Coney, 1991, p.59), and early claims that surgical removal of the ovaries would ‘cure’ PMS (Laws, 1985, p.26).

Texts one and seven view perimenopause predominantly from a biomedical perspective. Both texts have doctors as authors. However, all of the texts use words that are symbolically medical. “Symptoms”, “patients”, “treatment” and “prescription” are some examples. This use of medical terms leads to an association of perimenopause with disease or illness (Lyons & Griffin, 2003, Discussion and implications, paragraph 3). Also, detailing the symptoms as a ‘set of symptoms’ has the effect of encouraging a woman, who experiences one
symptom, to anxiously await the other symptoms (Richards, 1997, p.102). Markens (1996) states that defining PMS as a medical problem attributes pathology to women’s bodies (p.47). In defining perimenopause also as a medical problem needing management, women’s bodies are pathologised at yet another stage of their lives (Laws, 1985, p.23).

All of the texts concentrate mostly on the physiological side of perimenopause: “this particular imbalance between oestrogen and progesterone is at the root of most perimenopausal symptoms” (Text two, Jackson, 2004, p.21). Some of the language used implies breakdown, inadequacy or loss of function (Martin, 1992, p.44) within the body: “deficiency or excess” (Text two, Jackson, 2004, p.42) and: “erratic ovarian function” (Text six, Stamm, 2004, n.p.) and “irregularly irregular” (Text seven, Nachtigall, 1998, p.922). Spender (1985) has commented on the use of labelling and demeaning language, which promotes and perpetuates gender inequality (p.139). Text seven perpetuates this inequality:

This group is known as “the sandwich generation”, caring for their immediate families and ageing parents as well as having career commitments. (Text seven, Nachtigall, 1998, p.921).

These words also subtly refer to the traditional role of the woman staying in the home, and being the nurturer (Martin, 1992, p.121).

The sandwich generation! I love it! Where on earth did Nachtigall get that from? And where would I fit in to her description? I’m perimenopausal, but I don’t have children / immediate family to look after. And my parents are far from needing MY help. So what type of sandwich would I be? Ham and mustard on rye, perhaps? Toasted cheese and tomato? What a degrading description of perimenopausal women this is. Journal extract.
All of the texts suggest some way of managing perimenopause. Those texts with an obvious medical slant recommend hormonal treatment, but differ as to which hormonal treatment. Goldstein and Ashner, both in text one and text six, advocate the oral contraceptive: “Today, low dose birth-control pills are the most effective treatment for perimenopausal symptoms” (Text one, Goldstein & Ashner, 1998, p.48). Three of the other texts, however, talk about HRT as a way of managing perimenopausal ‘symptoms’:

“she can find relief through...accepted hormone replacement therapy” (Text seven, Nachtigall, 1998, p.921).

“...HRT remains a good short-term treatment for severe perimenopausal symptoms” (Text nine, McVeigh, 2005, p.22).

“...probably nothing else [besides HRT] will work” (Text three, Marinos, 2005, p.48)

The ‘natural’ approach in text two actually means the use of bioidentical hormones, instead of synthetic ones, in order to bring “you and your hormones back into balance” (Text two, Jackson, 2004, p.18). Text eight doesn’t specify which particular form of medical management should be used, only that yoga can help “supplement” any “medical support” (Text eight, Khalsa, 2004, p.170).

In text five, Dr Phil indicates that he considers perimenopause to need management when he asks Gittleman “What’s the most important first step in treating perimenopause?” (Text five, http://www.drphil.com/shows/show/167, emphasis added). All of the questions and answers in text six relate to symptoms and treatment; other issues that may impact on perimenopause are not addressed.

There are suggestions of other forms of management, such as supplements and lifestyle changes, but these are overwhelmed by the medical management. Text
seven does concede the possibility of other options, but these are not discussed. In text one, on the other hand, Goldstein and Ashner write scathingly about the use of alternative options by perimenopausal women:

...just because they come from plants and are available at health-food shops is no reason to think any of them is preferable to medication that is government regulated, tested on thousands of women, and successful with millions of patients. *Just because it comes from nature doesn’t make it better.* ...Nature can be very cruel. Nature lets mothers die in childbirth. (Text one, Goldstein & Ashner, 1998, pp.70-71, emphasis in original)

_I find this quote is so patronising! Every fibre of my womanly/nurse/midwife being rises up to smite these words. Where is the evidence for what Goldstein and Ashner are saying? These words are intended to produce guilt and control, in my opinion. Guilt, because mothers have guilt thrust upon them throughout their lives, and control, by getting women to consume vast quantities of drugs that will change their womanly characteristics._

Journal extract

Nowhere amongst all these options is there the choice to do nothing, to take no action at all. According to these texts, one cannot just simply ignore perimenopause; one has to manage it somehow. Thus the woman who wishes to take no action, who wants to locate herself outside the treatment discourse, has no frame of reference from which to work (Lyons & Griffin, 2003, Discussion and implications, paragraph 3).

In many of the texts, the doctor is seen as the expert, the person with the knowledge. The perimenopausal woman, as one who knows her own body, is referred to in only two of the texts. In text five, Dr Phil’s interview with Gittleman places her at the centre of expertise, a woman who has experience and knowledge in dealing with perimenopause (Text five,
http://www.drphil.com/shows/show/167). However, in exhibiting this knowledge, she uses the format of a doctor’s talk show; her expertise is undermined, because the doctor is seen as authenticating her words. Lyons and Griffin (2003) noted that even in the self-help books which had women authors, the doctor was still viewed as the expert on menopause (Discussion and implications, paragraph 8). Text nine positions women “who were assumed to be perimenopausal” (McVeigh, 2005, p.23) as those with the knowledge when it comes to discussing “common perimenopausal symptoms”, and the “level of distress” caused by these “symptoms” (McVeigh, 2005, p.23). In this text, McVeigh (2005) compares the information obtained from the women with that presented by medical experts, and finds interesting differences (p.25).

Text four has the potential to speak powerfully from the point of view of a perimenopausal woman. Yet Oprah moves quickly to cast doubt on her own interpretation of menopause (http://www.oprah.com/health/omag/health_omag_200208_menopause.jhtml). Oprah does refer to another woman for assistance, but that woman is a doctor. Women have internalised medical conceptualisations of the way in which their bodies function, leaving them to doubt their own expertise and knowledge of their bodies (Murray, 1996, p.1; Laws, 1985, p.20).

The use of women’s stories about frightening perimenopausal symptoms and ‘treatment’ can be seen to validate (Markens, 1996, p.48) the existence of perimenopause as a distressing problem that needs medical assistance. The women’s words perform an important function in validating a homogenous view of perimenopause (Butler, 1992, p.15; Flax, 1992, p.454), one in which normal bodily processes are seen as abnormal.

In text five, Gittleman and Robin pass up the opportunity to strike a balance between normal physiological changes and the unpleasant and disruptive changes experienced by a minority of women. Instead, an array of negative symptoms is recounted by Gittleman: “depression, forgetfulness, anxiety and sleeplessness”, and “…all those moodswings” (Text five,
She embellishes the recitation with fear: "I thought, I was going crazy" (Text five, http://www.drphil.com/shows/show/167). Her remedies, the peri zappers, further reinforce the perception that management is needed. Robin validates the authenticity of the peri zappers: "...everything that worked for me, was in her book" (Text five, http://www.drphil.com/shows/show/167).

2. Perimenopause is confusing and contradictory

Confusion is a consistent theme across all of the texts. The cover of text one (see Figure 1) shows a woman with a perplexed and anxious look on her face. Even the title of the book alludes to the possibility that there is much uncertainty about the subject of perimenopause. The cover of text two shows the author with a stethoscope around her neck, a symbol usually associated with doctors; however, Jackson is a nurse. Three of the texts (texts three, four and eight) switch between perimenopause and menopause in their discussions, leaving the reader uncertain as to which particular time period is being discussed.

Lyons and Griffin (2003) noted a 'confusion' discourse in their analysis of self-help books on menopause. They concluded that this discourse helped to construct menopause as a perplexing condition, for both women and health professionals (Lyons & Griffin, 2003, Discussion and implications, paragraph 4). Similarly, according to texts one to nine, confusion and contradiction are major factors in perimenopause. This may be because there appears to be difficulty in reaching a consensus regarding the definition of perimenopause. Text one states that perimenopause is caused by "fluctuating levels of oestrogen with no progesterone to balance it (sic)" (Text one, Goldstein and Ashner, 1998, p.15). Text two, although it promotes a 'natural' approach, defines perimenopause in the glossary as:

The years leading up to menopause – usually between the ages of thirty-five and fifty – during which hormones fluctuate and birth
control pills or HRT may be prescribed. Symptoms include mood swings, depression, hot flashes, insomnia, weight gain, fatigue, and low sex drive. (Text two, Jackson, 2004, p.167).

Text nine gives a definition that is both vague and technical: “a few years before and one year after the permanent cessation of menses” and: “perimenopause is marked by FSH (follicle stimulating hormone) > 30 mIU/ml” (Text nine, McVeigh, 2005, p.22). In text six, ‘Dearest’ asks Goldstein and Ashner to explain the differences between perimenopause and postmenopause. The guests respond, qualifying their definition by stating that there is “tremendous confusion between peri, post and menopause” (Text six, http://www.power-surge.com/transcripts.goldash.htm p.1), alluding to the possibility that doctors themselves may be confused about these definitions. Text seven rejects the WHO definition (1996), stating that a “better working definition” is as follows:

It is the phase preceding the onset of menopause, generally occurring around 40-50 years of age, during which the regularly cycling woman transitions to a pattern of irregular cycling and increased periods of amenorrhea, with associated symptoms reflecting hormonal changes. (Text seven, Nachtigall, 1998, p.922).

Two of the articles do not give any definitions for perimenopause, and text four merely states that perimenopause “begins years before a woman’s last period” (Text four, http://www.oprah.com/health/omag/health_omag_200208_menopause.jhtml).

There is also no consensus about common ‘symptoms’ of perimenopause. Text one states categorically that there are two types of perimenopausal symptoms: bleeding and psychological (Text one, Goldstein and Ashner, 1998, p.23), and that hot flushes and night sweats are associated with menopause (Text one,
Goldstein and Ashner, 1998, pp.174-177). However, text seven names hot flushes as the second most common symptom of perimenopause (Text seven, Nachtigall, 1998, p.924), and text three concurs. Text four only mentions one symptom: palpitations (Text four, http://www.oprah.com/health/omag/health _omag_200208_menopause.jhtml), and text five dwells mostly on the psychosomatic symptoms: “depression, forgetfulness,...anxiety...irritability....frustrations” (Text five, http://www.drphil.com/shows/show/167). In text nine, the psychosomatic symptoms, as reported by the women themselves, are also the most common (Text nine, McVeigh, 2005, p.24).

The onset and timing of perimenopause appears to cause confusion as well. Five of the texts suggest that perimenopause commences around the age of thirty-five. Text two clearly situates perimenopause between the ages of thirty-five and fifty (Text two, Jackson, 2004, p.167). Text eight gently alludes to the possibility of perimenopause beginning in the thirties: “A woman should begin shifting her diet and exercise routing at age 36, consciously responding to internal changes even before she may feel them as symptoms” (Text eight, Khalsa, 2004, p.170). Text four states that perimenopause “can start as early as 35 and last anywhere from 5 to 13 years” (Text four, http://www.oprah.com/health/omag/health.omag_200208_menopause.jhtml).

The medical and allied health articles do not clarify the age at which perimenopause may begin, but do give some estimate as to how long this period may last. Text nine states that perimenopause lasts “on average 7 to 10 years and [spans] up to 25 years” (Text nine, McVeigh, 2005,p.21). Text seven considers the time period is shorter: “the 2-8 years preceding menopause and the 1 year after the final menses” (Text seven, Nachtigall, 1998, p.922).
My sister phoned today; as usual I directed the talk to my thesis! She said that she had had two weeks of hot flushes and night sweats, but both these and her periods have stopped. The hot flushes were not too bad, but she hated the night sweats. She said that a woman in her office, aged over sixty, is still suffering badly with hot flushes. Hope I’m not still having hot flushes in fourteen years’ time!

This theme extends to the management of perimenopause. As noted above, all of the texts indicate that some form of management is necessary. The contradiction arises in the types of hormonal treatment. Two of the texts state that the hormones should be ‘natural’ (meaning bioidentical) and individualised, but even this option is considered only “if the synthetics don’t work” (Text five, http://www.drphil.com/shows/show/167).

The message given by the confusion theme is that perimenopause is an unclear and contradictory time: “it is one of the least understood,…and most confounding stages in a woman’s life” (Text one, Goldstein & Ashner, 1998, p.6). It is therefore no wonder that the doctors are confused as well: “Doctors didn’t know what it was” (Text five, http://www.drphil.com/shows/show/167). Lyons and Griffin (2003) also noted a theme of confusion in the discourse of menopause (Menopause as confusing, paragraph 1). Women’s bodies were viewed as “complex”, and menopause made them even more “complicated” (Lyons & Griffin, 2003, Discussion and implications, paragraph 3).

However, women are reassured that they can and should still rely on medical and allied health practitioners for explanations and advice. The authors of text one assure the woman reader that she “will know what is going on in [her] body” (Text one, Goldstein & Ashner, 1998, p.7), and text two is confident that it will provide “practical, step-by-step solutions” (Text two, Jackson, 2004, back cover). Text three is not as confident; it advises readers that it will “try to separate the fact from the fiction” (Text three, Marinos, 2005, p.46, emphasis added). In text four, Oprah considers it a “miracle” that she discovered
Northrup's book, and was thus able to solve her dilemma (Text four, http://www.oprah.com/health/omag/health_omag_200208_menopause.jhtml). The implication is that whilst the medical profession may be confused about perimenopause, they are still the experts to turn to for explanations and recommendations. Women remain therefore, under their control, and are undermined as experts of their own bodies (Laws, 1985, p.20).

3. Perimenopause is to be feared.

Fear is a powerful weapon. It can be used to exert control. Martin (1992) suggests that fear was used to keep women in the home, where they could not possibly take part in any occupation that was considered unfeminine (p.115). Similarly, the fear of 'losing control', through hot flushes and hot emotions in menopause, and the fear of ageing, has kept the pharmaceutical companies that manufacture HRT in business (Coney, 1991, p.163). Numerous legal cases have promoted the perception that women with PMS should be feared, avoided even, as they can kill (Laws, 1985, p.12; Johnson & Kandrack, 1995, p.25).

In all of the texts in my study, there is the suggestion that perimenopause also holds an element of fear. Indeed, merely the description of a perimenopausal woman is enough to cause dread:

Imagine a woman between thirty-five and fifty. A spare tire (sic) is developing around her middle, and bags have made unwelcome appearances beneath her eyes. Hot flashes come and go throughout the day, and night sweats interrupt her sleep. She is exhausted, can’t seem to concentrate, and alternates between depression and flying off the handle. Upset and anxious, she seeks help for the unpleasant physical and emotional changes that are crowding the good times out of her life. (Text two, Jackson, 2004, p.1).

However, some of the texts make this fear explicit. In text four, Oprah heads her article: “Be aware, be very aware” (Text four,
She also tells readers that the perimenopausal symptom she experienced caused her to think that she was “going to die” (Text four, http://www.oprah.com/health/omag/health_omag_200208_menopause.jhtml).

The title of text two, *The Hormone Survival Guide for Perimenopause*, suggests a condition that could possibly have fatal consequences (Text two, Jackson, 2004, front cover).

The picture on the front cover of text one is of a woman who is anxious or fearful, and who is wondering how she can “overcome” the horrors of perimenopause (Text one, Goldstein & Ashner, 1998, front cover). The message to readers is one of suspicion that she may not, in fact, prevail over the condition. The theme of fear is continued in the text, where the authors discuss issues such as surgery and cancer (Text one, Goldstein & Ashner, 1998, contents list). The information on cancer is included, despite the authors’ reassurance that a perimenopausal woman is “not a high risk (sic) for any of the gynaecological cancers” (Text one, Goldstein & Ashner, 1998, p.127).

Osteoporosis is a condition that is generally connected with women, mostly menopausal women (Gullette, 1997, p.184; Coney, 1991, p.81). Information about osteoporosis is generally provided in an atmosphere of dread. Gullette (1997) calls this technique the “quick-step bone-mass sequence: osteoporosis leads to falls, fall (sic) to fractures, fractures to expense and death” (p.184). Three of the texts here allude to a connection between osteoporosis and perimenopause. Text six recommends the drug Evista as a way of preventing osteoporosis: “Excellent choice. Evista preserves bone, prevents fractures, lowers breast cancer, lowers uterine cancer, lowers cholesterol....little to lose” (Text six, http://www.power-surge.com/transcripts.goldash.htm). Text one links osteoporosis to perimenopause by talking about the age (mid-thirties) at which bone loss can commence (Goldstein & Ashner, 1998, p.183). In text five, Gittleman encourages women to exercise regularly: “you’re building strong bones for menopause” (Text five,
http://www.drphil.com/shows/show/167). Thus, a clear overlap between the discourse of menopause, and perimenopause can be seen.

Most of the articles have lists of symptoms; by grouping all the symptoms together in this fashion may lead to the belief that if one has one symptom, one must expect the other symptoms as well (Richards, 1997, p.102). Numerous symptoms are named on the covers of the self-help books. Some of the in-text language perpetuates the fear factor:

Other perimenopausal women are hanging on for dear life as they ride the hormonal roller coaster, plunging from the highest highs to the deepest lows in a matter of twenty-four hours (Text two, Jackson, 2004, p.12, emphasis added).

Text three attempts to ‘bust myths’ about some perimenopausal symptoms, so that women will not worry; Gullette (1997) suggests that this technique actually succeeds in telling women what there is to worry about (p.184). Few of the texts qualify the universality of the symptoms of perimenopause, thus treating women as one homogenous group (Butler, 1992, p.15), and suggesting that all perimenopausal women should dread this time period.

4. Perimenopause is a time for rejuvenation


Seven of the other texts concur with Oprah. One example is: “Make it a priority to learn to live to the fullest within your changing body” (Text one, Goldstein & Ashner, 1998, p.221). Another example is: “Ideally, perimenopausal women are in a place where they can implement dietary changes, self-help measures, and other lifestyle improvements” (Text two,

If menopause is a time of degeneration (Martin, 1992, p.51), perimenopause is a time of rejuvenation. In our present culture, “Healthiness has replaced Godliness” (Lupton, 1995, p.4) as the means by which good citizens are measured. Sybylla (1997) suggests that a woman is conditioned to scrutinise herself and discover that “lo!...she is what the experts say she is” (p.201). She admits that she needs transformation, or rejuvenation, rather than expecting patriarchal society to accept her as she is (Sybylla, 1997, p.201).

Lyons and Griffin (2003) found that menopause was presented as a ‘change’ (Menopause as the change, paragraph 1); indeed, it is known colloquially as ‘the change’ (Greer, 1991). This change is not only inevitable, it is negative, stressful, sudden and out of the control of women (Lyons & Griffin, 2003, Menopause as the change, paragraph 4). Perimenopause, on the other hand, is depicted in the texts as a time of growth, spiritually, intellectually and emotionally. Women may become confused and frightened, but they do have chances to exert some control over their path through perimenopause (Text two, Jackson, 2004, p.xv).

The texts do not qualify why the responsibility for rejuvenation should fall on the shoulders of perimenopausal women in particular. Many of the methods suggested for achieving rejuvenation are lifestyle techniques that, ideally, should be lifelong practices: good diet, exercise, adequate health care, positive mental attitude, and so on. Text four does suggest that the forty-something body may not be able to tolerate poor habits as well as the twenty-something body can, and the body may therefore retaliate: “If you keep this up, I’m gonna make you old” (Text four, http://www.oprah.com/health/omag/health_omag_200208_menopause.jhtml).

There are various and many suggestions for achieving a rejuvenated body. Text four mentions a few: “…getting adequate sleep, balancing your diet, drinking
Text four, http://www.oprah.com/health/omag/health_omag_200208_menopause.jhtml). Text two devotes many pages to achieving a balance: “Getting your liver in shape” (p.56); “A six-step plan for weight/fat loss” (p.64); “The Quick-Fix plan for stress” (p.86); “Simple exercises for improved body image” (p.105); “The Quick Fix plan for energy” (p.121); and “Establishing better sleep patterns” (Text two, Jackson, 2004, p.139).

Text one states that low-dose birth control pills are the first option when it comes to rejuvenation, as they “restore health” (Text one, Goldstein & Ashner, 1998, p.49). This phrase echoes the words of Dr Wilson, the gynaecologist who declared oestrogen to be the wonder drug for menopausal women (Coney, 1991, p.59). A good diet, plenty of weight-bearing exercise and a positive outlook on life are also important for perimenopausal women, according to text six (Text six, Stamm, 2004, n.p.). Increased knowledge helps women to “feel more in control of their bodies” as well (Text one, Goldstein & Ashner, 1998, p.213). This enlightenment “helps the doctor, too” to make “the correct diagnosis” (Text one, Goldstein & Ashner, 1998, p.213).

Text eight advises women to, of course, take up yoga, as well as to rest: “it is advisable for every woman over 50 to take an 11-minute nap daily”, to use water to “cool and calm the heat…and the toughest emotions”, and to address their “psychological and spiritual well-being” (Text eight, Khalsa, 2004, p.172). Other than “exercising for at least 45 minutes, 3 times a week, and eating a balanced diet…rich in…soy products, nuts and pulses” (Text three, Marinos, 2005, p.48), text three does not suggest any other ways for rejuvenation. In fact, it does not offer any advice on how women can even achieve these goals.

If perimenopausal women are indeed “sandwiched” (Text seven, Nachtigall, 1998, p.921) between caring for both their growing children and their ageing parents, and trying to maintain a career, there is often little room left for fitting in forty-five minutes of exercise, and searching for delicious recipes for tofu.
Texts one, two and eight do offer more practical step-by-step advice on how to achieve an improved lifestyle, but once again, the advice is directed at the individual level only. Any societal factors, which may contribute to women not achieving their goal of rejuvenation, such as women having a second, unpaid job in the home (Markens, 1996, p.48), are not addressed.

In talking to women about their experiences of menopause, Richards (1997) found that those women who felt that they had ‘taken control’ of their lives, and had made changes, were “unusual” and “unusually articulate” women (p.78). The average woman-in-the-street, who may not have the educational or social advantages of an “unusually articulate” woman, may not, therefore, have the privileged opportunity for rejuvenation.

The texts imply that women are still held responsible for the management of their rejuvenation. This is achieved through self-surveillance. Danaher, Schirato and Webb (2000) maintain that self-surveillance is the “most economical form” of surveillance (p.76). Once people have been taught how to be ‘docile bodies’ (Cranny-Francis, Waring, Stavropoulos, & Kirkby, 2003, p.189), they continually search for any signs within themselves of “wrongness” (Laws, 1985, p.20). Sybylla (1997) writes about how the body is always the target in the creation of these docile populations; in fact, the body and the self cannot be separated from each other (p.214).

Thus, women are warned that they need to keep a watch for perimenopause, because “if you don’t recognise that it’s happening, you can’t do anything about it” (Text five, http://www.drphil.com/shows/show/167). Once the condition has been recognised, women are obliged to “[take] care of perimenopause” (Text five, http://www.drphil.com/shows/show/167). According to Gittleman, they do this by using her peri zappers (Text five, http://www.drphil.com/shows/show/167). Monitoring the condition of the body takes place through testing of the saliva, hair follicles and blood (Text five, http://www.drphil.com/shows/show/167). Not only do women have to consider their present perimenopausal deficiencies, but they also have to think of the

The task of attending to one’s emotions and monitoring one’s health through self-discipline has its rewards: “women...learn that discipline brings an enormous amount of self-satisfaction” (Text one, Goldstein and Ashner, 1998, p.216). Or, in text five, as Robin found out after following Gittleman’s advice: “I think I am a healthier person at 50 than I was at 40” (Text five, http://www.drphil.com/shows/show/167).

Text seven is the only text that does not suggest rejuvenation for perimenopausal women. As this article is aimed at the medical profession, and is thus overwhelmingly medical in nature, the implication is that there is no need to consider any lifestyle changes for the “patient” (Text seven, Nachtigall, 1998, p.921), as these will make no difference to the outcome. Text nine, also aimed at the health profession, appears to reject any idea that women can achieve any rejuvenation on their own: “...practitioners should offer programs aimed at ...improving general health status” (Text nine, McVeigh, 2005, p.26, emphasis added).

I wonder whether all of these suggestions for rejuvenation actually make the women FEEL empowered. They may have the responsibility for their own health management, but they actually don’t have any authority over it, do they? 

Journal extract.
CHAPTER 6
CONCLUSION

The aim of my thesis was to explore current representations of perimenopause. I have chosen nine texts from three categories, and I have discursively analysed them, at the same time comparing the representations of perimenopause in the texts with feminist analyses of PMS and menopause. I have detailed four themes that I consider to be present across all categories of texts. These themes are: firstly, perimenopause is a medically defined condition that needs management; secondly, perimenopause is confusing and contradictory; thirdly, perimenopause is to be feared; and fourthly, perimenopause is a time of rejuvenation.

The word perimenopause is significant in itself. This word is in all nine texts, texts which are products of individual, organisational, technological or cultural activities (Reinharz, 1992, p.147). Separately, these texts might be insignificant, yet when they connect with one another, as I have connected them within this thesis, each text is made meaningful (Phillips & Hardy, 2000, p.4). I argue then, that perimenopause is not just a new word in our (gendered) language, but a distinct discourse.

Parker (1992) suggests that discourses have particular hallmarks. First, he suggests that discourses create a concrete reality (Parker, 1992, p.8). In describing perimenopause, the texts have certainly made perimenopause a reality. Furthermore, as I have shown, the concentration on the predominantly physiological aspects of perimenopause, without taking into account the many ways in which life impinges on women, is reductionist (Brook, 1999, p.52). The subtleties and nuances – individual, cultural, economic and social - of women’s lives are subsumed under the concrete weight of the perimenopausal physical reality.
Authority is another feature of a discourse (Parker, 1992, p.9). In this case, the dominant institution of patriarchal medicine has infused a sense of authority and knowledge about perimenopause into the texts, using women’s possible concerns over health, ageing and their roles in life. Cranny-Francis, Waring, Stavropoulos and Kirkby (2003) comment on the way that institutions focus our attention on certain issues, using methods that seem part of our daily lives (p.47). Here, I, as the subject, have been addressed by the texts as a perimenopausal woman who could be frightened and confused, but in whom there is the possibility of rejuvenation (to avoid expensive medical costs to the nation, of course). The perimenopausal woman who does not view herself thus, may have no other frame of reference on which to draw (Lyons and Griffin, 2003, Discussion and implications, paragraph 2).

As a discourse, perimenopause exhibits coherence (Parker, 1992, p.10). There is internal validity in the perimenopausal world portrayed in these texts. It is held up to women as rational and real. It makes sense of women’s lives: “Feeling fat? Out of sorts? Inexplicably sad? Or even feel like ripping someone’s head off? Don’t worry. Hormonal imbalance can do that.” (Text two, Jackson, 2004, back cover). The fragments of women’s lives, so perplexing to those who would wish to document or monitor them, have been bundled together into a patterned system (Lupton, 1992, p.145). This system is coherent also in the way that it is simplified and accessible to women: “Let me say this book is so great because it’s accessible. There’s not a lot of mumbo-jumbo. It's a list of day-to-day, practical, things to do.” (Text five, http://www.drphil.com/shows/show/167).

Perimenopause is similar to and refers to other discourses (Parker, 1992, p.12), namely PMS and menopause. I have shown the crossover in the main themes in the texts analysed, and there are other examples (text two, the self help book by Jackson, contains a chapter on PMS). PMS and menopause are represented as abnormalities or pathology, that require medical attention (Greer, 1991, p.18; Markens, 1996, p.47). In a similar way perimenopause is depicted as a time in
women’s lives which is probably frightening and confusing, but for which there is help from health professionals. Negative images, language and stereotypes, similar to those used in the discourses of PMS and menopause, are also utilised to describe perimenopause.

Perimenopause was first defined by the WHO in 1980 (WHO Report, 1996, p.2); however, by the way it has been described differently in these various texts, it has since evolved and had many “layers” (Parker, 1992, p.15) attached to it, another feature of a discourse. Parker (1992) also states that, often, discourses talk about issues which have always been present (p.16), but which can be appropriated for various purposes. In a sense, then, we are at an historical point (Parker, 1992, p.15) with regard to perimenopause. Perimenopause, as the period of time pre or around menopause, has always been a part of menstruating women’s lives. But as I have argued, it has now been appropriated by the main institutions of society (patriarchal medicine being the dominant one, the media being another). Perimenopause is represented at the minimum as a problem, at the maximum as a pathology, thus, arguably, reinforcing the dependence of women on those institutions and disempowering women in their daily lives. At this historical moment, when women have achieved increased social and economic power following the decades of the second wave of women’s liberation, they are shown to be at the mercy of perimenopause.

This does not imply though, that women are merely victims – of the medical establishment, of the media, or of their own biology. This provides a far too simplistic analysis and would only add to “all the women of the world lying like squashed ants beneath the increasing load of sociological documentation of men’s power over them” (Wearing, 1996, p.32). With regard to perimenopause, as a discourse, its power relations are complex. The diversity of women must always be acknowledged; further, “the subject woman is not a monolithic essence defined once and for all, but rather the site of multiple, complex, and potentially contradictory experiences” (Braidotti, 1997, p.27).
This has certainly been my experience as a perimenopausal woman, as both a subject and object of this research. However, it must be noted that the first three themes identified in my analysis contribute to the depiction of the perimenopausal woman as dependent, scared and confused. The fourth theme of rejuvenation depicts a different woman, one who is vital, informed and empowered. But, as Richards (1997) says: empowered to do what? (p.101). To be empowered, one is "lesser" than the more powerful authority that is investing the power (Lupton, 1995, p.60). Perimenopausal women may have difficulty realising that empowerment, when faced with the 'expertise' and dominant ideology of patriarchal medicine.

Perimenopause is then, I argue, certainly a discourse, and one with implications for women. With the realisation of this discourse, the whole reproductive life of a woman is potentially controlled by patriarchal ideology (Laws, 1985, p.23). In perimenopause (as a period that lay descriptions suggest could cover fifteen years of a woman’s life) there is menopausal 'bracket creep'. The adult woman is thus pathologised for much of her adult life. The accentuation of the medical profession as experts with regard to women's bodies, is reinforced (Greer, 1991, p.25) and extended. The physical, emotional and psychological changes in perimenopause are described as pathological, and in so doing, they become 'normalised' into society's view of perimenopause. Perimenopause is increasingly being represented as a major issue in and for women's lives; it cannot be ignored.

This thesis is a small study of nine texts. Overall, the study revealed negative implications for perimenopausal women. There was some ambiguity in the texts, and therefore the promise of positive implications, especially in the rejuvenation discourse, can be seen. There was little opportunity for the diverse experiences of perimenopausal women to be heard or discussed; the overwhelming body of knowledge provided was medical in nature. Perimenopausal changes were not, on the whole, described as normal; this has
the effect of encouraging unhealthy attitudes towards women’s bodies (Johnson & Kandrack, 1995, p.26).

This analysis may therefore provide suggestions for further research. If women are given the opportunity to voice their experiences (positive or negative) of perimenopause, a wider body of knowledge can be obtained. Differences in experiences could possibly be seen as just differences, rather than pathology. A narrative of the experiences of some perimenopausal women could ascertain how these women view themselves. Do they see themselves as subjects situated within the dominant perimenopausal discourse? Or are they defining their own discourses? (Martin, 1992, p.22).

Yes, I am a perimenopausal woman, ‘sandwiched’ between the red tent and the red haze. And yet, against all perimenopausal odds, I have achieved the completion of this thesis. This is cause for jubilation.  Journal extract.
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Appendix C

Don’t believe everything you hear about menopause. Sarah Marinos talks to an expert to find the truth behind the myths.
With lubrication or oestrogen preparations, such as creams and vaginal suppositories, which stimulate vaginal secretions. Ask your GP for advice.

Menopause may not be the only factor, says Dr Farrell. "If a woman has been with her partner for years, she may feel that the span has left their relationship. Children may be leaving home, and around the age of menopause, women renegotiate what they're doing with their life. They want to fulfill their own needs rather than on thinking of everyone else first. Issues such as stress, health, family and relationships, and menopausal experience can all cause sexual problems."

Myth #3 Women put on weight

"Around the age menopause occurs, our metabolism slows and that triggers weight gain," explains Dr Farrell. "Younger women who have premature menopause may not put on the same degree of weight in the same way as older women experiencing menopause do, so that indicates that weight gain is age related."

For most women, exercising for at least 45 minutes, three times a week, and eating a balanced diet, will help to fight this weight gain.

Myth #4 All women become depressed

Menopause doesn't cause depression, however, during perimenopause, the fluctuating hormones may lead to mood swings. Women who have had a history of either depression or premenstrual syndrome may be more sensitive to these hormonal changes.

Menopausal "madness" or melancholia is a myth, explains Dr Farrell. "It's true women with mood changes who say they'd like to be able to separate what is hormonal and what is due to everything else in their life. Menopausal signals the end of family, so it can be a time of sadness, especially if a woman has lost children or was never able to have them. Menopause forces women to realize the aging process is starting and that can be hard for a while."

Myth #5 Hormone therapy is essential

Hormone therapy (HT) used to be called hormone replacement therapy (HRT).

For women who moderate the severe menopausal symptoms, probably nothing else will work, explains Dr Farrell. But many women handle mild symptoms without HT. "A diet rich in plant-oestrogen foods, such as soy products, nuts and pulses, helps ease the symptoms, she says. "Exercise is very important for wellbeing and mood. It helps with sleep problems and improves the cardiovascular system and bone strength."

If you want to use natural therapies, consult a qualified practitioner with expertise in women's health.

Myth #6 Hormone levels must be measured

"We measure hormone levels in young women when trying to diagnose if they're at early menopause, or when we are trying to work out why periods have stopped for a reason other than menopause," says Dr Farrell. "Sometimes, when a woman has a hysterectomy, we check hormone levels to test the absorption of oestrogen from gel or patch or implant."

For most women, though, the hormone levels change rapidly from day to day, so during perimenopause, it's better to monitor daily symptoms."

Myth #7 Having a hysterectomy will bring it on early

Ten to 30 per cent of women who have a hysterectomy go through menopause one to four years earlier than they would have done naturally. It also occurs about one and a half years earlier in smokers.

"The uterus is supplied by the uterine artery, which also sends blood to the ovaries. During surgery for hysterectomy, the surgeon has to interfere with that blood supply, which may be a stimulus to turn off the ovaries," says Dr Farrell.

Myth #8 A bone density measurement is crucial

Osteoporosis occurs when bones become fragile and break more easily because of calcium loss. Around one in three women over 65 have a fracture. HT reduces the risk and decreases fractures of the spine by up to 40 per cent. It also reduces hip fractures.

"Women may have a bone density test when there are risk factors for osteoporosis, such as a family history, a sedentary lifestyle or a low calcium diet," says Dr Farrell. "Treatments for severe asthma, an erosive thyroid and rheumatoid arthritis can affect bone density and strength, as well. Each woman should be assessed about her risks of developing osteoporosis to decide whether a test for bone density is necessary."

For more information, you can visit www.menopause.org.au or call 1800 131 441.
Appendix D

My body sent me its first wake-up call more than a year ago, on an evening I'll never forget. One night last June, I—someone who has had every heart test known to womankind and has been repeatedly reassured that I have no blockages—awoke with my heart palpitating so intensely that it felt like it was going to beat right out of my
chest. Pound! Pound! Pound! For the first time in my life, I thought I was about to die.

A doctor's visit confirmed what I'd already been told: I don't have heart disease. Over the next six months, my attempts to figure out what I did have led me to four more doctors—and not one could explain the palpitations. Then one morning when I was out running, I mentioned the palpitations to my trainer, Bob Greene.

"I think it's the big M," he said.

"The big M what?" I shot back.

"I think it's menopause," he said.

I stopped and stared at him. "Of course it's not menopause!" I said. "I'm still having my periods. Regular as rain!"

Like nearly every other woman in America, I believed that menopause would hit when my periods ended—that I'd suddenly wake up one day during my fifties in a fit of hot flashing. Yet over the next few days, Bob's words stayed with me: Could he be right? Of the five doctors I'd visited, two were female. Neither had asked whether I, then age 47, might be nearing one of the major markers of a woman's life. I finally put the question directly to my fifth doctor, a heart specialist: Could I be entering menopause?
"Well, if it's menopause, ma'am," he said, chuckling, "you're definitely in the wrong place! I don't know a thing about that."

What happened next can only be called a miracle. A few days later, I was walking around the Harpo offices when I noticed a book called *The Wisdom of Menopause*. I opened it right to page 456, where I saw a subtitle that seemed to shout directly at me: "Palpitations: Your Heart's Wake-Up Call." I spotted a woman's story that sounded exactly like my own: "I am a 48-year-old female with no major health problems." Check. "My periods are still fairly regular." Check. "About a month ago...I started experiencing heart irregularities. I felt like my heart was skipping a beat and was going to beat out of my chest!" Double check. Then I saw the line that clarified everything: "There's no question that heart palpitations at menopause are related to changing hormones."

(Before you declare yourself perimenopausal—peri means near or around—hear this: A racing heart could be a symptom of a life-threatening condition, like heart disease. If you experience irregular heart rhythm, please get to a doctor right away.)
Shortly after my revelation, I made a call to the woman who wrote *The Wisdom of Menopause*—Christiane Northrup, M.D., an expert on holistic healing and women's health. Dr. Northrup says that perimenopause begins years before a woman's last period. It can start as early as 35 (yes, 35) and last anywhere from 5 to 13 years. In this country, the average age at which a woman has her final menstrual cycle is 51. And here's a kicker that'll keep you using birth control into your fifties: An entire year must pass after your final period before you can be certain that you've absolutely stopped producing eggs.

Here's what I realized after reading all 498 pages of *The Wisdom of Menopause*: Everything you've always known about taking care of yourself—getting adequate sleep, balancing your diet, drinking water, exercising regularly—comes into sharp focus during this phase. Perimenopause is your body's way of shifting your full attention back onto your well-being. "When you don't take care of your body in your twenties," Northrup says, "you can get away with it. But as you move toward your forties, your body says, 'If you keep this up, I'm gonna make you old—but if you stop now, you'll get a second chance'"
At Dr. Northrup's suggestion, I cut out what I call the white stuff—high-glycemic-index foods such as potatoes, white rice, refined sugar and bread that throw my insulin level out of whack, cause weight gain, and trigger palpitations. I'd already cut out salt months before, believing that my racing heart might have been a symptom of high blood pressure. After just four days of swearing off the white stuff, my palpitations completely ended.

So many women I've talked to see menopause as an ending—a loss of youth, autonomy and vitality. But I've discovered that the approach of menopause is a knock at the door that can prompt you to finally create the life you've always wanted. This is your moment to reinvent yourself after years of focusing on the needs of everyone else—your mate, your children, your boss. It's your opportunity to get clear about what matters to you, and then to pursue that with all of your energy, time and talent.
Appendix E

"Let me say this book is so great because it's accessible," says Dr. Phil. "There's not a lot of mumbo-jumbo. It's a list of day-to-day, practical, things to do. I think it's a great resource for everybody."

Ann Louise explains: "The reason I wrote the book is that I thought I was going crazy until I realized that I was really going through 'the change.' Doctors didn't know what it was, so I had to do a lot of research myself. I think enlightened self-interest is the best reason for doing any of this investigation. If it can help me, it can help all of the women on the show."

Robin adds: "I researched and read everything that I could find in the bookstores and on the internet. I researched doctors daily, and tested everything and found that everything that worked for me, was in her book."

Dr. Phil asks Ann Louise, "What's the most important first step in treating perimenopause?"

"Number one, if you don't recognize it's happening, you can't do anything about it,"
replies Ann Louise. "Perimenopause is occurring in women as early as 35 years of age. That means so many of us will be going through symptoms like depression, forgetfulness, anxiety and sleeplessness. Women will be going to doctors who think they should be getting medicated rather than taking caring of perimenopause."

Dr. Phil adds: "When I was in practice, I had so many patients come to me with perimenopause that were on everything from Prozac to Elavil, antianxiety, antidepressants, and massive dosages of estrogen."

"Yes," says Ann Louise, "And that's totally wrong because what we're learning is that we have too much estrogen in the environment and many of us are not estrogen deficient. We're deficient in another very important hormone, progesterone."

Dr. Phil asks Ann Louise to review her perimenopausal treatment method, what she calls her "Peri Zappers," designed to 'zap' the symptoms of perimenopause.

Ann Louise starts out: "My 'Peri Zapper'
number one, which is good for perimenopause and PMS, is flaxseed oil. You should get one to two tablespoons of flaxseed oil a day. Or get the ground up flaxseed and put it on your oatmeal or your popcorn. It's a great source of natural hormone balancing, and it keeps your blood sugar level so you won't go up and down like a rollercoaster.

"Number two is evening primrose oil. It's a PMS 'Peri Zapper' because the two are very closely aligned. Two weeks before your period, start taking at least 1000 milligrams of evening primrose oil, half in the morning, half at night. It's a great way to relieve irritability, menstrual headaches, as well as water retention and painful breasts."

Also, Ann Louise says women should take multi-vitamins, "But more importantly, magnesium. We've been sold a bill of goods about how important calcium is. It is important, but just as important, if not more so, is magnesium, especially with those mood swings and all that anxiety and irritability that women feel. Right before going to bed, I'd like about 400 milligrams of magnesium on everybody's night table, Dr. Phil."
Another mineral Ann Louise recommends women take is Zinc. "Zinc is an anti-anxiety mineral," says Ann. "It's very important as a precursor of progesterone to balance all the extra estrogen. Which is next, the progesterone cream. You can put that on topically. Just rub a little on the throat, some of the fleshy areas of the inner arms, even the palms.

"Exercise is next. You're venting all your frustrations, you're building strong bones for menopause, which is going to occur at about the age of 51. So we're going to build up and get some good lifestyle practices."

Ann Louise continues: "Next, you need to de-stress some stress. That's important because the more stressed we are, the more we use up our magnesium and our zinc."

Dr. Phil adds: "I found over the years, that there are certain types of massage that can help, like acupuncture point massage, and certain types of music can be helpful in de-stressing. Next, tell us about adrenal refresher."

"The adrenals are your backup system once you hit 'the change,'" says Ann Louise. "So you want to make sure those are really strong so you can withstand stress better. Take soy phytohormones in moderate amounts. We now know that too much soy can actually backfire on the system.

"And then last but not least, natural hormone therapy. If the synthetics don't work, you can always go to a natural compounding pharmacist and get a prescription that's individualized to exactly what you need."
Dr. Phil asks Robin, "What's worked best for you, because you've tried it all?"

"First of all," says Robin, "Before I started anything, I did the saliva testing, the hair follicle testing and the blood testing. I found out what minerals I was deficient in, and did mineral I.V.'s, and got myself healthy. I did everything naturally, I didn't want to do any synthetic medications. I do everything on Ann Louise's list... I go to a compounding pharmacy, use an estrogen cream, my progesterone is natural, and I supplement with all the essential oils."

Dr. Phil mentions, "Robin is so into all of this. That's why we're doing this show. She kept telling me, 'You need to call Ann Louise. You need to do this show. This is a big deal!'"

Robin adds, "I believe now, after doing everything that I found worked for me, and then finding it in Ann's book, it's made everything so simple for me. I think I am a healthier person at 50 than I was at 40."
Appendix F

Power Surge™ Live!
Host: Dearest
Guests: Dr. Stephen Goldstein
and
Laurie Ashner

Order "Could It Be....Perimenopause?"

Dr. Steven Goldstein
Dearest: Tonight's guests came to my attention when co-author, Laurie Ashner, a Medical Journalist, Researcher and Author was seeking resources on menopause on the Internet. Her search brought Laurie to Power Surge and I'm so proud to be included in (5 pages) of their new book, "Could It Be....Perimenopause?" (Little Brown) as "the premier site for women in menopause on the Internet." (blushing with pride).

Laurie Ashner and the physician behind the book, Dr. Stephen R. Goldstein, have written one of the clearest and most readable books on menopause I've yet seen (and that's a lot). Dr. Goldstein is a Professor at New York University School of Medicine; Director of Gynecologic Ultrasound, Co-Director of Bone Densitometry at NYU and the immediate past Chairman of the American College of Obstetrics and Gynecology for New York. (Where on earth does he find time to write books) :)

Every paragraph of "Could It Be....Perimenopause?" is chock-a-block full of the "Questions Women Ask"- the questions WE ask, not simply medical lingo many of us simply don't understand. Questions like:

"I'm 51 and I'm spotting every day. Is this normal like a long last period?" ...
"Is compulsive eating a symptom of perimenopause?" ...
"I'm becoming forgetful and accident-prone. Is this due to perimenopause?"

Dr. Goldstein and Ms. Ashner discuss HRT, SERMS (Raloxifene), HMO's, birth control pills and natural treatments for perimenopausal symptoms, too!
It's my pleasure to welcome you both to Power Surge :). Could you begin by explaining the differences between "perimenopause" and "postmenopause?"

Dr. Goldstein and Ms. Ashner: I think there's tremendous confusion between peri, post and menopause. Menopause is when there is absent estrogen due to a lack of ovarian function. Perimenopause is characterized by fluctuating levels of unopposed estrogen secondary to anovulation, or lack of ovulation. It is the change in estrogen levels that results in many of the symptoms of perimenopause, rather than the absent estrogen of menopause.

Dearest: So, would it go without saying that once those estrogen levels have "leveled out" -- the uncomfortable symptoms associated with perimenopause will disappear?

Dr. Goldstein and Ms. Ashner: You have to realize that there is a difference between absent estrogen and dry vagina, skin changes, decreased libido and the transitional symptoms of the perimenopause. Initially the hot flashes are related to very low and absent levels of estrogen.

Dearest: You mean the severe hot flashes we experience during Perimenopause while we're still menstruating are due to low and absent levels of estrogen?

Dr. Goldstein and Ms. Ashner: The subtle changes that we speak about in the book occur sometimes up to ten years before the first hot flash or vaginal dryness. Yes, those hot flashes are due to that although rising FSH (follicle stimulating hormone) may also play a role.
Dearest: Don't the FSH levels rise as the estrogen drops?

Dr. Goldstein and Ms. Ashner: Realize that paradoxically late in the perimenopausal transition, there will be estrodiol levels in a premenopausal range while there are FSH levels in a postmenopausal range. In many women FSH rises while estrogen does not fall to menopausal levels as quickly.

RKP50: Could you explain the benefits of taking Evista over the other designer estrogens. I have felt so sick on HRT. I am about to start on it and I am worried that I will be sick again.

Dr. Goldstein and Ms. Ashner: Designer estrogen is a poor term. Evista is a SERM-- Selective Estrogen Receptor Modulator. That means it acts like estrogen in some tissues -- bone, lipid, etc. while being an estrogen blocker in reproductive tissues. (Breast, uterus). It is not estrogen. It should not be confused with estrogen. It has great potential for extending postmenopausal women's health, but it is NOT a treatment for menopausal symptoms (hot flashes, etc.)

Dearest: Others have reported that Raloxifene can even cause hot flashes.

Dr. Goldstein and Ms. Ashner: No. In 24 percent of the women in clinical trials reported hot flashes at some time in the clinical trials over two years, but only 1.9 percent discontinued the study because of hot flashes. The implication is and it has been my clinical experience as well, that they are mild and short lived.

BARANDSTEP: I have had daily breast discomfort and tenderness. Is this a symptom and what can one do about it?
Dr. Goldstein and Ms. Ashner: Symptom of what?

BARANDSTEP: Either peri or menopause? Due to unopposed estrogen.

Dr. Goldstein and Ms. Ashner: Perimenopause, certainly--this is usually an estrogen effect. You would not expect breast tenderness in menopause.

RCHCTH: If you're having very heavy periods, wouldn't adding ERT make it worse?

Dr. Goldstein and Ms. Ashner: Absolutely it would. There's a difference between replacing estrogen in menopause and using ultra low dose birth control pills in perimenopause. ERT does not turn off the erratic ovarian function of perimenopause. Low dose birth control pills shut down your own ovarian function and substitute a small amount of estrogen and progesterone all month long.

Dearest: Dr. Goldstein, you write about the new low-dose estrogen/progesterone therapy, a la HRT or BC pills. I even read where you talk about the almost non-existent risk of stroke. Do you believe these low-dose pills are so much safer than we are told?

Dr. Goldstein and Ms. Ashner: In non-smokers, Dearest, yes. The total estrogen in pre menopausal woman on these pills may in fact be LESS than what your own body makes monthly. People are confused because clearly in post menopause, if you take HRT, your body and your breasts will have more circulating estrogen than if
you don’t take HRT. But with birth control pills, remember they SHUT DOWN estrogen your ovary is making and substitute an even smaller amount.

Dearest: I had a doctor in Power Surge who told us any woman who smokes is "safe" taking HRT. What are your feelings about this? It goes against everything I’ve ever read about HRT and smoking.

Dr. Goldstein and Ms. Ashner: Smoking and HRT -- Standard HRT is about one half the dose of 20 micrograms birth control pills. I think any woman who smokes and uses estrogen at any dose is playing with fire, no pun intended.

GMAMATT: Do the hot flashes ever subside and does sleep return to normal if one isn’t on hormones? Do you recommend Evista?

Dr. Goldstein and Ms. Ashner: In the overwhelming majority of women, the hot flashes and sleep disturbances are marketedly diminished over 12, 18, 24 months. A very small percent of women, may be affected over a longer period of time.

Dearest: Dr. Goldstein, what women are NOT candidates for hormone therapy?

Dr. Goldstein and Ms. Ashner: Are we talking replacement or birth control pills in terms of who is not a candidate?

Dearest: Wouldn’t it be pretty much the same for both?
Dr. Goldstein and Ms. Ashner: Yes, with the caveat of the smokers. Birth control pills are contraindicated in smokers over 35, but HRT is not such an absolute.

MMSCHEER16: I'm having hot flashes and feeling sick to my stomach and tenderness in my breast is there any thing I can do? Any medications?

Dr. Goldstein and Ms. Ashner: Are you still getting periods?

MMSCHEER16: Yes

Dr. Goldstein and Ms. Ashner: Two month trial of 20 microgram birth control pills. In addition, exercise, anti oxidant vitamins, moderate alcohol, low fat diet will all help. They apply to everybody, perimenopausal, or not.

MMSCHEER16: How would I get that?

Dearest: MMSCHEER, best thing is to get it from your doctor.

Kaaitjie: I am post-menopausal (no period for 18 months) & using compounded "natural" HRT. What regimen would you recommend for post menopausal me/women?

Dr. Goldstein and Ms. Ashner: What do you perceive to be the benefits of "natural" HRT?
Kaaitjie: Right now I'm not sure - I'm not having flashes, bone density OK, high blood pressure though. I could not use regular HRT - migraines

Dr. Goldstein and Ms. Ashner: Many many people equate natural with risk free. Just because it comes from a health food store doesn't mean it's safe. There are many phyto estrogens that are powerful. If they relieve hot flashes, you should realize that your breasts are seeing it as estrogen too, except it has no quality control, or standardization like pharmaceuticals do.

Sealoom: Dr. I am 43 full blown menopause for at least a year. HRT made me sick so I am taking Pro-Gest cream and soy protein. My blood test came back low on estrogen. the doctor wants to put me on estrogen and I don't want to because it makes me sick. Any advise? The doctor said that in 6 months if the estrogen is not higher he wants me on it.

Dr. Goldstein and Ms. Ashner: For patients like you with premature ovarian failure, I often still use 20 microgram birth control pills because a younger woman like you has even higher estrogen requirements than someone older first going through menopause. You will do better (all of the people in this room) if you markedly restrict your salt intake while on birth control pills or estrogen and add 200 mg vitamin B-6 time-released a day

Dearest: Dr. G and Laurie, what would be your suggestions for women who are postmenopausal and who can't take HRT?

Dr. Goldstein and Ms. Ashner: I depends on why you can't take HRT, and is the goal treatment of symptoms or extending health.

Dearest: Extending health. Can't take HRT - history of phlebitis and don't prefer HRT and its risks, to say nothing of its side effects.
Dr. Goldstein and Ms. Ashner: Extending health? Then it depends on what the reason is to not take HRT. Are you a candidate for Evista?

Dearest: I, personally, am not a candidate for most drugs. I don’t react well.

Dr. Goldstein and Ms. Ashner: Watch your diet, stay on antioxidant vitamins and B-6. Don’t discount Evista, it may be what you need, since it lowers breast cancer, lowers uterine cancer, preserves bone, prevents fractures and lowers cholesterol. It’s the most exciting drug to come along since penicillin.

Dearest: I treat all those with vitamins, minerals, herbs and phytoestrogens. I got thru the worst part of menopause without hormones. Think I’ll make it through the rest :) Mom just turned 87 :)

RCHCTH: History of breast cysts, will ERT make cysts worse and breasts more tender? (in peri)

Dr. Goldstein and Ms. Ashner: Absolutely. You should consider 20 micro birth control pills, decrease salt, decrease caffeine. The problem is your own FLUCTUATING estrogen. Birth control pills will turn that off. You’ll feel better, your breasts won’t hurt. But you must decrease salt and caffeine.

Dearest: Can you make the distinction between 20 mcg of BC pills and traditional ERT menopausal women take? Thanks
Dr. Goldstein and Ms. Ashner: The total effective estrogen of 20 mcg pills is about double .625 milligrams of conjugated estrogen. But remember that the BCPs TURN OFF your own ovarian production and substitute this low dose instead.

Dearest: Then wouldn't 20 mcg BC pills put us more at risk for cancer?

Dr. Goldstein and Ms. Ashner: Than what? It doesn't put you at more risk because it turns off the estrogen you're already making.

Dearest: But it's adding synthetic estrogen to your body, right? I'm confused here

Dr. Goldstein and Ms. Ashner: A point I'm trying to make is if you're post menopausal all you need all you need is .625 mg of conjugated estrogen is sufficient unless you are under age 45. This dose in perimenopausal women, however, will not be able to SUPRESS your own ovarian production. 20 mcg bcp pills are the lowest dose effective to do this.

Dearest: Interesting. Another point, we're told to take conjugated estrogens for heart health....yet I've read that they can elevate triglycerides which contribute greatly to heart problems. What are your thoughts?

Dr. Goldstein and Ms. Ashner: The relationship between estrogen and heart disease as mediated through the SECONDARY markers, known as lipids is still unclear. Yes estrogen raised triglycerides (not a great thing) but estrogen increases HDL (a very great thing). Hopefully the Women's Health Initiative will yield some answers.
Dearest:  Yes, we're all looking forward to those results in 2005

Annetteb2:  I'm 49-- many symptoms, yet have regular periods. I am presently taking natural progesterone (capsules). When the time comes is there a natural estrogen and when should I consider it is time?

Dr. Goldstein and Ms. Ashner:  When you stop having any vaginal bleeding. Vaginal bleeding is a sign of enough estrogen priming of the uterus. The use of progesterone, natural or otherwise, can help to regulate your bleeding pattern, but will do little for the symptoms of fluctuating estrogen.

Howard1978:  I'm DES exposed and have trouble with synthetics because of bad receptors. Is there a *safe natural estrogen? I'm 41, started periods again after using progest cream

Dr. Goldstein and Ms. Ashner:  This is a case when you should see your doctor. DES exposure usually causes anatomic changes in the genital tract, but I am unaware of any changes to overall estrogen receptor function. Obviously, yours is a unique case, and you should discuss this with your doctor.

Lrj48:  I am 50; went into meno early--at 43 & took HRT for 7 yr.--just had hysterectomy w/ovaries removed, and I'm wondering if I should take testosterone in addition to estrogen now

Dr. Goldstein and Ms. Ashner:  Testosterone with estrogen helps with libido in about 50 percent of patients who have that problem. In that case I'd say, other functions of testosterone are not well studied or understood. The jury is still out.

Lrj48:  Is there any point other than libido? Are you saying there's no evidence?
Dr. Goldstein and Ms. Ashner: Other than libido, in my clinical practice, that's been the only significant addition of testosterone.

GMAMATT: Wanted to know more about Evista. Went off HRT after ten years, concerned about long term use causing breast cancer. Dr. wants me to take Evista for bone health

Dr. Goldstein and Ms. Ashner: Excellent choice. Evista preserves bone, prevents fractures, lowers breast cancer, lowers uterine cancer, lowers cholesterol. It's worth a try. Little to lose.

JanNJess: at 45 had precancer in breast, on tamoxifen until 50, had total hysterectomy at 46, off tamoxifen now. mood swings, weight etc. Any suggestions?

Dr. Goldstein and Ms. Ashner: Were your ovaries removed? If yes, it's a tough one. I'd definitely consider Evista. I cover this in my book "The Estrogen Alternative" (Putnam)

Sue: If taking the low dose BC pills turns off your ovarian function, what happens when you stop the BC pills? How long do you normally keep someone on such a treatment program?

Dr. Goldstein and Ms. Ashner: Until around age 50. Soon, after coming off the pill, ovarian function resumes. Around age 50 in women on dose pills you can check FSH on day 6 on the pill free week and if it is elevated, you can switch the patient to more traditional forms of HRT.
Sea loom: Dr. since I haven't had a period in over a yr.(43 yr. old). HRT made me sick. Would you prescribe birth control or Evista and why can't I get the same amount of estrogen from soy protein the natural way?

Dr. Goldstein and Ms. Ashner: I would give someone your age 20 mcg birth control pills and then the amount of soy you would have to ingest would be 40 to 50 grams a day. It's not enough to sprinkle a little soy in your spaghetti sauce. It think soy may turn out to be a phyto SERM and I am very interested and following the research carefully.

Sea loom: What about eating enough of a half a block of tofu?

Dearest: You can get 184 mg. soy isoflavones in one Revival Soy Protein shake.

Dr. Goldstein and Ms. Ashner: You'd need forty of those shakes a day to get to the dose I'm talking about!

Dearest: Dr. Goldstein, why would you have to drink 40 soy shakes of 184 mg. soy isoflavones to get the same effect? Japanese women consume approximately 200 mg. of soy isoflavones in their diets daily. If I drank that many shakes, the flatulence alone would cause WW III :)

Dr. Goldstein and Ms. Ashner: The amount of breast cancer as well as menopausal symptoms in the Japanese culture is markedly less than here. However, the amount of soy in their diets is SIGNIFICANTLY greater than the soy protein shakes.
Dearest: Don't you attribute that, in good part, to their diet rich in soy isoflavones? A typical Japanese woman consumes approximately 200 mg. of soy isoflavones per day. Revival Soy Protein Shakes currently being used in research at Johns Hopkins, contain 184 mg. per shake. 200 mg. is sufficiently higher than 184 mg.?

Dr. Goldstein and Ms. Ashner: Probably, Dearest. But such a diet is difficult for most Westerners to adhere to.

Dearest: The soy shakes are delicious :) I have no problem with one shake per day.

Annetteb2: I am 49, perimenopausal on natural progesterone. At this time is testosterone indicated for loss of libido (which may be caused by a medication I am on and would taking soy protein at this point be detrimental?

Dr. Goldstein and Ms. Ashner: But what drug are you on that is affecting libido? Discover that rather than adding more irons to the fire.

Annetteb2: I am on Effexor however Dr. thinks the libido more than likely is hormonal.

Dr. Goldstein and Ms. Ashner: Have your doctor recommend something other than effexor. I have no data on how testosterone might interact with effexor.
Lrj48: You seem to think testosterone basically unnecessary; even if no ovaries? Is it only sex drive--I thought it might help w/overall energy level.

Dr. Goldstein and Ms. Ashner: I don't think testosterone is unnecessary, and I am saying the jury is still out. Pharmaceutical grade testosterone is only available with estrogen. Testosterone creams have poor quality control. I'm hoping that in the years that follow research will show better ways to administer testosterone if research shows it to be of value. The research on testosterone is really lacking. I can't really comment any further than what I've already said.

Lrj48: You said 200 mg B6 before, isn't that a lot? I looked at my multi-vitamin, and it is has only 5 mg. What does B6 do for you?

Dearest: 200 mg. B-6 is not a lot. I take 100 mg. B-6 3x per day

Sealoom: Dr. I took birth control pills for 3 weeks when I was 19. They made me sick too. If I can put in my body enough soy isn't that enough?

Dr. Goldstein and Ms. Ashner: This is a main theme of my book, Could It Be...Perimenopause?. The pills you took had FOUR TIMES the hormone of the ultra low dose pill we're speaking about today. Take vitamin B6, restrict your salt, and give them a two month trial.

Dearest: Dr. Goldstein and Laurie Ashner, thanks for joining us in Power Surge and fielding our questions about perimenopause, HRT, SERMs and your wonderful new book, "Could It
Be....Perimenopause?" Thank you, too, for the wonderful chapter on Power Surge in your book. We hope you'll come back and visit with us again very soon

Dearest: Dr. Goldstein, Laurie, please share the name of the newest book, too.

Dr. Goldstein and Ms. Ashner:"The Estrogen Alternative"

Dearest: Thanks and thank you for a wonderful chat tonight

Dr. Goldstein and Ms. Ashner: It was our pleasure. Thanks to all!

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aka Alice Stamm
Power Surge
Founder, Facilitator, Host

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Appendix G

The Symptoms of Perimenopause

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Until recently, the time just before and just after the last menstrual period has been little understood and ignored both in the literature and in clinical practice, despite the impact on patients' quality of life. Of late, however, thanks to an increasingly growing population of women, medical science is beginning to examine and treat the symptoms that so often accompany the years that precede the menopause. No woman has the patience to suffer through as many as 10 years of symptoms until her last menses arrives and she can find relief through the adjustment of her estrogen receptors or treatment with accepted hormone replacement therapy (HRT).

By recognizing the perimenopause, and understanding the symptoms that accompany this period, we can truly improve the patient's quality of life, with treatment when necessary or with assurance when deemed sufficient.

Despite its importance to women and its potential medical consequences, perimenopause has not been widely recognized. Most women know only about menopause. When they have symptoms in their 40s, or while still having regular periods, they often misinterpret these symptoms, blame themselves and their life circumstances, and suffer quietly.

The increasing number of 40-54-year-old women in the population has began to change this situation. There are now more than 16 million women between the ages of 40 and 54 years in the United States. By the turn of the century, there will be nearly 19 million. These are the women who are now in their perimenopausal years and they are vocal and determined to be informed. This group is known as "the sandwich generation," caring for their immediate families and aging parents, as well as having career commitments. These full and demanding lives do not leave time or patience for perimenopausal symptoms. Diagnosing and providing appropriate treatment for perimenopausal symptoms will not only improve patients' quality of life during the years before cessation of menses, but it may also increase the likelihood that patients will actively seek, and be willing to comply with, HRT during the menopausal years.

Every healthcare practitioner knows exactly what menopause is; and, thanks to media attention, just about every woman knows as well. Perimenopause, however, is surrounded by a great deal more confusion. Unlike menopause, which can be strictly
delineated and defined as the time point 12 months after the final menses, timing of the perimenopause is unclear. Similarly, unlike the absolute increased follicle-stimulating hormone (FSH) and dramatically decreased estradiol levels that define the menopause, the perimenopause is characterized by far more fluctuation and is, in fact, defined by its “irregularly irregular” hormone levels.1 This ill-defined period of life was defined by the World Health Organization (WHO) as the 2–8 years preceding menopause and the 1 year after the final menses.2 A better working definition was used by Dr. Bachman et al at a seminar on Perimenopause. It is the phase preceding the onset of menopause, generally occurring around 40–50 years of age, during which the regularly cycling woman transitions to a pattern of irregular cycling and increased periods of amenorrhea, with associated symptoms reflecting hormonal changes.

The perimenopause is a highly individual process. No two women will have the same perimenopause experience or timing. Not many studies have been done on the variability of length of perimenopause, but both McKinlay3 and Traylor4 suggest a duration of 4 years on average, with a range of 2–8 years. Clinically, however, it is not unusual to see a patient who has had a duration of 10 years.

Ovarian mass changes throughout the life span as a function of age, and these changes have been demonstrated with particular clarity in a classic study by Tervila, in which he examined 706 pairs of ovaries on autopsy. Tervila showed that ovarian weight increases steadily during early development, but that it begins to drop precipitously, not after menopause, but rather after age 35 (Figure 1).3 The decrease in mass accelerates after age 45, when the ovary shrinks even more rapidly.

A steady depletion of primary ovarian follicles occurs as well, beginning during fetal life and continuing until menopause. Histologic examination of the perimenopausal ovary shows a reduced number of primary follicles with rare secondary or graafian follicles or well-developed corpus luteum (Figure 2).5,8 Studies of menstrual cycle duration during the perimenopause have shown that intermenstrual intervals shorten significantly before the onset of the overt menstrual cycle associated with the more advanced stages of the perimenopause. Women report a 3-day decrease in intermenstrual interval. Accelerated folliculogenesis appears to be the cause of this process.6 In comparison with those of younger women, levels of FSH increase in women in the perimenopause.4 This may be interpreted as compensation for a decreased number of ovarian follicles,10 or as a consequence of decreased secretion of inhibin.11

Measurement of FSH and estradiol which are extremely variable during this period and are of limited clinical value and are not necessarily recommended as part of the diagnostic process. Levels of luteinizing hormone (LH) are highly variable as well,
and are of even less value in diagnosing perimenopause.

An FSH level can be useful, however, in assessing fertility in the perimenopausal-aged woman who is considering pregnancy. An FSH level measured on the third day of the menstrual cycle (FSH level is less than 20 mIU/ml, pregnancy is still a possibility; if a patient’s FSH level is less than 20 mIU/ml; and a level of 30 mIU/ml indicates menopausal ovaries and no possibility of pregnancy.

**Symptoms of Perimenopause**

Symptoms form the basis of the diagnosis of perimenopause. Presenting symptoms are extremely variable among women. Therefore, a highly individualized approach to both evaluation and treatment is recommended. A summary of perimenopausal symptoms appears in Table 1.

**Changes in Menstrual Pattern**
The most common symptom of perimenopause is a change in menstrual pattern. Some 90% of women will experience alterations in menstrual cycles during this time. Shorter cycles, by between 2 and 7 days, are most typical. For example, women who had regular 25- to 35-day cycles during their 20s and 30s will begin to have more frequent cycles, mainly because of shortening of the follicular phase. Previously consistent 28-day cycles may become 25-day to 26-day cycles, and as perimenopause proceeds, the prevalence of oligomenorrhea increases. Irregular bleeding.

**TABLE 1. Perimenopausal Symptoms at a Glance**

<table>
<thead>
<tr>
<th>Changes in menstrual pattern</th>
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<tbody>
<tr>
<td>Shorter cycles most typical (eg, by 2-7 days)</td>
</tr>
<tr>
<td>Longer cycles possible</td>
</tr>
<tr>
<td>Irregular menses possible</td>
</tr>
<tr>
<td>Change in quality of bleeding</td>
</tr>
<tr>
<td>Usually heavier at first due to anovulatory cycles, then lighter</td>
</tr>
<tr>
<td>Spotting may immediately precede menses</td>
</tr>
<tr>
<td>Heavy, prolonged, or intermenstrual bleeding</td>
</tr>
<tr>
<td>Not normal in perimenopause</td>
</tr>
</tbody>
</table>

- Vasomotor instability
  - Hot flushes
  - Night sweats
- Sleep disturbance
- Psychological/cognitive disturbances
  - Worsening PMS symptoms
  - Depression
  - Irritability
  - Other mood changes
  - Poor concentration, forgetfulness
- Sexual difficulties
  - Prevalence of sexual difficulties in perimenopausal women variable and increases with age

**Symptoms**
- Decreased vaginal lubrication
- Decreased libido
- Dyspareunia
- Vaginitis

**Somatic symptoms**
- Headache (worsening of menstrual migraines)
- Dizziness
- Palpitations
- Breast pain and enlargement

*Consider as endometrial biopsy*
may occur at the end of an inadequate luteal phase or after a peak of estradiol that has not been followed by ovulation and corpus luteum formation. Longer cycles are also possible, as are irregular menses.

Many women also note a change in the quantity of bleeding. Bleeding is usually heavier early in perimenopause because of anovulatory cycles. Therefore, it frequently becomes lighter. Many women also report spotting on the day or two immediately preceding menses. The combination of spotting, shorter cycles, and heavier bleeding may leave the patient with the subjective impression that she is always bleeding.

Although irregular bleeding is quite common and considered normal, during perimenopause, heavy, prolonged bleeding or bleeding between menses is not normal. The presence of such bleeding should serve to alert the clinician to consider further evaluation, such as an endometrial biopsy for diagnosis, particularly in patients with other risk factors for endometrial cancer, such as oligo-ovulation, obesity, or history of infertility. In equivocal cases, before undertaking a biopsy, it may be worth while to ask the patient to complete a bleeding diary to obtain more accurate information about bleeding pattern.

VASOMOTOR INSTABILITY

Vasomotor disturbances are second only to irregular bleeding in their frequency during perimenopause. Approximately 85% of perimenopausal women experience the hot flushes, night sweats, and sleep disturbance that are symptomatic of vasomotor instability. The intensity, duration, and frequency of these symptoms are highly variable. While some women may experience 40 flushes per day and drenching night sweats, some may have 1-2 per day and are hardly bothered.

During a perimenopausal hot flash, finger temperature has been found to increase by an average of 3.1 ± 0.3°C, and the elevation persists for an average of 44 minutes. The mechanism of the perimenopausal hot flush is not completely understood. Although changes in thermoregulation, immunoreactive neuropeptide, catecholamine, and LH have all been noted during hot flushes, rapidly decreasing levels of estradiol are the most consistent finding and the factor believed to be most contributory.

SLEEP DISTURBANCES

Sleep disturbances of varying degrees of severity are frequently reported by women in perimenopause. Sleep disturbances may vary widely and may be chronic or transient. Several common patterns have been reported, including:

- difficulty falling asleep
- awakening in the middle of the night with trouble resuming sleep
- early-morning awakening with an inability to resume sleep.

Sleep difficulties can seriously affect quality of life, resulting in fatigue, irritability, and inability to concentrate.

Confirming sleep disturbances. Healthcare providers must distinguish whether sleep disturbances are secondary to night-time hot flushes, are associated with depression, or arise from other causes, listed below:

- Hypothalamic disturbances almost always result in sleep latency
- Habits (such as daytime naps and an irregular sleep schedule) may result in night-time sleep disturbances
- Stimulants (such as caffeine, alcohol, nicotine, and some prescription drugs) can disturb sleep, as can illness, anxiety, or emotional concerns.
- Physical discomfort (such as arthritis pain) may result in difficulty in initiating or maintaining sleep
- Nocturia may result in frequent awakening

The most common sleep disturbance in the perimenopause is a lengthening of sleep latency (from the time of the patient lying down to the time of actually falling asleep).
Normally, this should not exceed 10 minutes. 16

PSYCHOLOGICAL/COGNITIVE DISTURBANCES
Psychological and cognitive symptoms, including depression, irritability, other mood changes, and poor concentration and forgetfulness, are also present in many perimenopausal women. Many women describe these disturbances as "severe PMS." Indeed, it is widely agreed that, in this age group, what has historically been termed premenstrual syndrome is probably a collection of perimenopausal symptoms.1

Controversy continues to surround the issue of whether the incidence of depression increases during the perimenopause and menopause. We do know that women have approximately twice the incidence of depression that men do; the lifetime risk for major depressive disorder is 7–12% for men and 20–25% for women. The gender difference begins in the adolescent years and does not end with perimenopause. The mean age of onset of depression is 30 years. 17 Laboratory data indicate that the ovarian hormones are potent, peripherally generated chemical signals affecting neuronal activities. Changes in estrogen and progesterin levels have been shown to influence numerous central nervous system (CNS) neurotransmitters, including dopamine, norepinephrine, acetylcholine, and serotonin, all of which are known modulators of mood, sleep, behavior, and cognition. During perimenopause, fluctuating hormone levels, and particularly fluctuation in estrogen levels, may alter levels of CNS neurotransmitters, thus contributing to sleep, memory, and mood symptoms and leading to difficulty in coping with psychosocial stressors in women who have previously had no particular difficulty in this regard. 17

In view of these findings, the clinician should maintain a high index of suspicion for depression in all female patients, including perimenopause-aged patients. It is important that hormone-related mood changes be distinguished from a major depressive disorder. If the patient has no history of depression, HRT should then be considered.

SEXUAL DIFFICULTIES
During the transition to menopause, as estrogen levels decline, sexual difficulties are reported with increased frequency. The prevalence of such difficulties tends to increase with age. Symptoms that may lead to or exacerbate sexual difficulties include decreased vaginal lubrication, decreased libido, dyspareunia, and vaginismus.18 Counseling regarding the normal progression of these changes is important because most women do not attribute them to hormonal causes. Instead, they and their partners, believing that sexual performance and interest do not begin to change until menopause, may erroneously blame sexual problems on interpersonal difficulties. Women are reassured to learn that these changes are a normal part of the perimenopausal transition.1

It is not surprising that research has shown a correlation between declining estradiol levels, hot flushes, and frequency of sexual intercourse.19

VULVOVAGINAL EFFECTS
In perimenopausal women, genital complaints are common and require an accurate diagnosis to receive proper treatment. Vaginitis, contact dermatitis, vulvar disease, and vulvodynia are among the possible diagnoses. Clinicians are advised to check for:

- Vaginal infection, including candidiasis, bacterial vaginosis, trichomoniasis, and sexually transmitted diseases
- Allergic reactions to chemicals in soap, bubble baths, spermicides, condoms, feminine hygiene sprays, or deodorant tampons/pads
- Irritation from tampons, a diaphragm, or a cervical cap left inside the vagina too long
- Routine douching
- Certain diseases, such as diabetes and Crohn disease

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Some perimenopausal women may report vulvovaginal changes, such as vaginal dryness and/or itching, dyspareunia, and urinary stress incontinence. The first noticeable change is often reduced vaginal lubrication during sexual arousal. As estrogen loss increases as menopause nears, marked vaginal changes may occur. Changes may also be the result of a lack of sexual stimulation of the vagina. The vagina may shorten and narrow; the vaginal lining may become thinner, paler in color, and less elastic. A woman with this degree of vaginal atrophy may experience significant vaginal irritation and tenderness, especially as the ability to produce adequate vaginal secretions diminishes.

Libido changes can be decreased during this phase, but causes are complicated and extremely variable. Libido changes that are the result of vaginal problems are the easiest to correct.

**SOMATIC SYMPTOMS**

Several somatic symptoms are common during the perimenopause, including headache (and worsening of menstrual migraines), dizziness, palpitations, and breast pain and enlargement. The mechanism behind the increased frequency of headaches is fairly clear; as estradiol levels decrease, vasospasm increases because estrogen is known to be a vasodilator. The pathogenesis of breast pain and enlargement is less clear because this symptom is generally hyperestrogenic in nature. It probably depends more on the changeable levels in serum estradiol levels rather than to an absolute decrease in these levels. As is the case with all perimenopausal complaints, however, women need reassurance that these symptoms are both common and physiologically based. Treatment, along with educative and supportive counseling, should be initiated at the onset of symptoms. Not long ago, even if perimenopausal symptoms were diagnosed, clinicians had virtually nothing by way of effective treatment to offer these patients. Now, however, both pharmacologic and nonpharmacologic forms of treatment are available. It is neither necessary nor reasonable to tell women that they cannot be helped during the perimenopause because they are still producing their own estrogen. In many cases, reassurance that the symptoms are real and not life threatening maybe sufficient. But, when necessary, treatment should not be withheld.

**References**


Appendix H

How Yoga, Meditation, and a Yogic Lifestyle Can Help Women Meet the Challenges of Perimenopause and Menopause

Hari Kaur Khalsa, R.Y.T.

This article will present how yoga exercises, yoga meditation techniques, and a yogic/holistic approach to menopause can help women ease their symptoms, get effective assistance from their doctors, and find support in their communities during this physical, psychological, and spiritual transition.

Menopause is changing the face of medicine. Each day approximately 4,000 women in the US turn 50, making the transition into the “years of wisdom.” There were more than 40 million menopausal women in the year 2001. For women looking for a natural and healthy transition, as well as for a deeper meaning of menopause, yoga has much to offer.

Doctors and yogis agree that each woman has her own unique experience of menopause. Based on past and current physical health and lifestyle, psychological profile, support system in the community, and genetics, women can experience menopause quite differently. Most American women experience some underlying symptoms with differing degrees of intensity. These symptoms of the shifting
hormone levels include hot flashes, night sweats and disturbed sleep, mild depression and/or anxiety, and a desire to "put their life in perspective," or find purpose and meaning in life. Even healthy women, in excellent physical condition, living happy lives, with plenty of reserves, report that the transition is powerful enough for them to seek help from both medical and alternative sources of support. If a woman's symptoms are intense, disrupting her life, she can supplement any medical support with yoga, meditation, and relaxation. If a woman's experience is mild, she can still benefit from these techniques as they help her to adjust to a new body chemistry.

A woman should begin shifting her diet and exercise routine at age 30, consciously responding to internal changes even before she may feel them as symptoms. Certainly by the time a woman begins to feel the shifts in her menstrual cycle (getting further apart and/or closer together), or feels night sweats, or increased mood swings, she should tailor her self-care regime to support the perimenopausal transition. The vast tradition of yoga and meditation can assist women during this transition.

Yoga Postures and Exercise

Yoga exercise and postures should suit a woman's fitness level. Starting a yoga practice in a gentle way can give women the basics of the yoga perspective of the body and movement. From this basic knowledge and experience, women can choose either vigorous or gentle practice. Exercises that release tension around the lower back and ovaries, target the liver and adrenal glands, and make women sweat to stimulate the glandular system can help them maintain the best hormonal balance. (See Appendix.)

Walking is an excellent addition to yoga postures and exercise practice. A yoga walking technique adds mantra and breath techniques to a walking regimen that helps bring the activity to a meditative level. Walking with music helps women keep a steady pace for aerobic exercise. Fresh air and the movement of walking is considered as healthy for the spirit as for the body. Kundalini Yoga suggests that a woman walk three to five miles a day.

Meditation

Meditation is an important part of yoga practice. As much as stretching and moving help the body rest and rejuvenate, meditation is a healing balm for brain chemistry, helping to bring the mind to a state of awakened calm. Meditation and breath techniques are being studied by scientists to discover how they work. In helping people relax and lift their spirits. The meditations in Kundalini Yoga are described as benefiting the brain chemistry, the hormonal balance, and the stimulation of communication between the brain hemispheres.

As much as stretching and moving help the body rest and rejuvenate, meditation is a healing balm for brain chemistry, helping to bring the mind to a state of awakened calm.

A relatively new field of study called neuroanthropology—the study of the neurobiology of religion and spirituality—studies Zen Buddhists, Franciscaans, Franciscans, and other deeply devout individuals of all faiths. Practices of deep concentration and devotion can "create a reality different from and higher than the reality of everyday experience," according to psychologist David Wulf of Wheaton College in Massachusetts. Dr. Andrew Newberg at the University of Pennsylvania and his late colleague, Dr. Eugene d'Aquila, performed SPECT scans on individuals experiencing

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deeply meditative states. The results showed that deep meditation could create "roadblocks" to certain areas of the brain and thus produce feelings of timelessness and infinity.

Deep concentration, rhythmic movements, and repeated sounds, such as mantras, help tune out extraneous stimuli and activate the temporal lobe. This intense focus leads to heightened positive emotions. An intense focus also decreases input from the hippocampus to the orientation area of the parietal lobe—the area that tells us where our self ends and the rest of the world begins. Moreover, the parasympathetic nervous system is activated in yoga, thus helping to achieve relaxation and a heightened sense of spirituality (1.2).

Meditation often dramatically slows the heart rate to as low as four times per minute. We know that slowing respiration can move the body out of the fight-or-flight stress response and can deliver a more balanced mental state, a more awakened sensitivity, and a calm perspective.

Yogic breathing—slow and conscious breathing without strain in the upper chest—and meditation can help bring oxygen to the frontal cortex, the anterior cingulated gyr, and the temporal and parietal areas of the brain. It can help slow metabolism and help send energy to areas of the brain where it is most needed (3).

Many women report that meditation practice has helped them in other aspects of life. In menopause, women may assume new roles in their lives—the role of caring for aging parents, the role of letting go yet supporting their children as they move on, in career advancement—and in increasing community activities. Often they assume the role of spiritual family leaders, as they help parents and sometimes friends pass on. Meditation can help women fulfill these roles and stay steady and healthy during the mental and spiritual challenges of death and loss as well as the physical symptoms of menopause. If a woman practices meditation and relaxation techniques, she may be more likely to sense the symptoms of menopause clearly and be more aware of her physical and mental changes. Thus, she can work with her doctor more effectively and efficiently.

Many women also report that they have greater clarity and patience when they meditate, and that they can make decisions more easily. There are so many options for women: yet medical jargon, and a plethora of poorly understood studies can cause confusion. Trusting doctors and themselves can be difficult in this fast-moving information age. The simple practice of meditation can help a woman find her way with more patience and less fear.

Relaxation and Rejuvenation

Menopause is a time for women to think of rejuvenation. This can seem impossible, considering the many challenges they routinely deal with at this stage in life: teenagers, aging parents, extending families, rechallenged careers—as many roles to fulfill and so little time for rest and relaxation! From the yogic perspective it is essential for women to find time to rest. To ignore the body's request for rest is to challenge the immune system and bring on more serious physical illnesses and symptoms. These are bound to demand more time than would be spent for rest and rejuvenation.

It is essential for women to find time to rest. To ignore the body's request for rest is to challenge the immune system and bring on more serious physical illnesses and symptoms.

Hermenu Engleit has described the physiological aspect of the stress cycle. Under stressful situations the hypothalamus secretes corticotropin-releasing hormone (CRH); the CRH circul-
lates to the pituitary, which in turn releases the hormone adrenocorticotropic hormone (ACTH). ACTH stimulates the adrenal glands to produce glucocorticoid hormones, which put the body on the defensive. Engler mentions that daily stress may repeatedly activate this system, without allowing for recovery (4). Some psychopharmacologists consider the shifting hormone levels during perimenopause to be a stressor on the body and brain. It is vital for women to rest, rejuvenate, and learn to manage stress, as they are already under the stress of shifting body chemistry.

For many women who don't rest, the price to be paid is more intense symptoms, depression, and anxiety. It is advisable for every woman over 50 to take an 11-minute nap daily.

When in menopause—add water! Water is considered the woman’s element. A swim in fresh water or the ocean can cool and calm the heat of perimenopause and the toughest emotions that can accompany perimenopause. Sitting in a bath and “fighting” with the water, a technique called “Fighting with Father Neptune,” can relieve a highly charged emotional mood.

Finally, we should address the psychological and spiritual well-being of women in perimenopause and menopause. Women often work out their challenges through conversations with peers. Taking the time to be with friends, community organizations, support groups, or yoga classes (especially special classes and workshops that address women’s issues) can be of great value. A simple prescription of a weekly walk with a friend brings the benefit of shared experience. I once gave this “yogic prescription” to a woman who promptly burst into tears. She was that busy and lonely and starved for time with her friends. A weekly walk became an important part of stabilizing her menopausal transition.

Conclusion

A yoga regimen should fit a woman’s physical fitness level, and include breathing, meditation, and relaxation techniques. The best results are achieved if the student understands how to integrate mental concentration with the physical postures and exercises.

Kundalini Yoga is one style of yoga practice that integrates specified breathing techniques and mental concentration throughout all exercises. This type of yogic approach helps a woman in a holistic manner and gives her various techniques to address her specific issues. Many yoga teachers specialize in woman’s yoga, and a few private lessons can be helpful before joining a class. Suggest that a patient speak to the yoga teacher directly, explaining her goals. The teacher can then address her with specific supportive suggestions and practices.

It is suggested that women practice yoga daily, or a minimum of three times a week, to experience specific benefits from the practice. Women report that daily practice—even for a short time (with longer workouts in classes)—brings the best results. Learning to take time each day for self-care is both empowering for women and creates the best climate for positive results.

Photograph credits—


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References:
3. Ibid. p. 182.
APPENDIX

Some Beneficial Yoga Postures

Standing Liver Twist - Stand on your feet with your legs about 18 inches apart. Place your hands on your hips. Begin to make large circles with your upper body, stretching as you circle slowly around. Continue this circling motion for up to 11 minutes. This exercise massages the liver for a detoxifying and rejuvenating effect. (Fig 1A)

45° Blood Pose - On your back, grab your ankles and draw your heels to the buttocks, with the heels about 18 inches apart. Tighten your buttock muscles, raise your entire torso up off the ground, slowly as if massaging each part of your back, and arch your spine, as if pressing your navel point in the sky. Hold this position for up to 3 minutes, or move the body in synchronization with your breath, inhaling as you stretch up and exhaling as you relax your back down. This exercise helps to strengthen your lower back, and relieve tension in the ovaries. This is especially comforting when women are experiencing delayed periods and PMS in perimenopause. (Fig 1B)

Knees to Chest for Lower Back Relaxation - Lying on your back, gently draw your knees to your chest and hold them there with your hands. Relax your head, neck and shoulders. Relax your breath. You can gently rock side to side as well. This posture provides a gentle stretch for your lower back and massages your ovaries and reproductive organs. This is a rejuvenating exercise. Relax in this posture to help you tune into your body and let go of tension. (Fig 1C)

Tiger Pose - Sit on your right heel and extend your left leg straight behind you without bending your knee. Stretch up and let your head reach back comfortably in alignment with the arch of your back. Even as you arch your back, avoid compressing your lower spine and lift out of the stretch as you balance in the posture. If you can, lift your arms and balance as indicated. Begin long, deep, slow breathing. Build up slowly to holding the posture for up to five minutes (the goal for helping through menopause). Repeat the exercise by stretching the right leg back. This posture opens circulation to your reproductive organs and reduces tension in the lower back. The intense stretch in the lower back supports the functions of the ovaries, kidneys, and liver. It has a cleansing effect on the liver to help you prepare for and meet the challenges of menopause. (Fig 1D)
Cobra Pose — Lie on your belly. Place your hands beside your chest or shoulders. Inhale as you lift your head and shoulders, pressing your hips into the floor and tightening your buttock muscles. Using your hands as support, arch your back up, to a comfortable stretch. Keep your shoulders relaxed back and down without overstretching your lower back. Only come as high up as is comfortable. This posture increases the reproductive organs, releases back tension and stimulates the flow of energy throughout the body, for an overall healing effect. Practice this exercise after a half-wheel pose and follow it with knees to chest for a rejuvenating effect. (Fig 1E)

Fig 1E — Sit with your knees apart and your heels off the floor, touching each other. With your fingertips on the floor helping you support your weight, inhale as you straighten your legs and look at your knees, and exhale as you return to the squat. Repeat up to 26, or 54 times, or to your ability. An energizing and vigorous exercise, this posture can stimulate and help improve sexual function, increase glandular secretions throughout the body, distributes the powerful energies of the body so you feel alive, creative and inspired. Can make you sweat! (Fig 1F)

Helpful Meditations

Meditation to Release Stress — Sitting comfortably, place your hands together, palms facing each other in front of your chest. Touch the fingertips and thumbs of your right hand with the thumbs and fingertips of your left hand, forming a tepee shape with the fingertips pointing upward. Focus your eyes, open one tooth, on the tip of your nose. Inhale for 5 seconds, hold (suspend your breath without any stress) for 5 seconds, and exhale for 5 seconds. Repeat this slow breath 11 minutes or until you feel relief from the sensations of stress.

Meditation for Blossoming of Your True Self

Sit comfortably with a straight spine. Bring your hands in front of your chest, touching the base of your hands together but keeping the fingers open like a blossoming flower. Slowly open and close your fingers, as if opening and closing the flower. As you feel your fingertips opening and moving to touch each other and close, feel "I am infinity, I am the rose," just feel as if you are blossoming, opening up. This simple meditation is relating to the feministic spirit. It helps you call upon your inner resources and let the transition of menopause happen without resistance and upkeep.

Alternate Nasal Breathing

Sit in a comfortable meditative posture, either cross legged or in a chair with your feet flat on the floor. Hold your left hand with the first finger touching the thumbs, resting in your koss. Use your right thumb to close your right nostril as you inhale through your left nostril. When you reach a full inhalation
(with no force or strain) use the index finger of your right hand to close your left nostril and remove your thumb to open your right nostril. Exhale through your right nostril. When you reach a complete expiration, inhale through your right nostril. At your full inhalation, switch from your index finger to cover the right nostril with your thumb and exhale through your left nostril. Continue this sequence:

- Inhale left, exhale right
- Inhale right, exhale left
- Inhale left, exhale right

Breathe consciously long, deep breaths without lifting your shoulders or straining. You can concentrate on the sound of your breath or add a mantra such as “Sat Nam” (mentally repeating Sat on the inhale and Nam on the exhale—meaning “true name” or “truth here and now”). Breathe and meditate in this manner for 3 to 31 minutes.

Yogic science applies different attributes to left and right nostril breathing. Breathing through the left nostril (associated with right brain) is described as cooling and promotes a relaxed, receptive attitude. Breathing through the right nostril (associated with the left brain) encourages a warmer and more energized state. Alternate nostril breathing is a basic way to bring balance to the hemispheres of the brain. This can help you keep a sense of balance in your life even as your inner chemistry shifts during perimenopause.
Appendix I

Objective: To identify the most common perimenopausal symptoms experienced by a group of Australian women and explore the extent to which those symptoms were distressing.

Design: A quantitative survey.

Setting: All women's health centers listed with the New South Wales Women's Information and Referral Service.

Participants: A convenience sample of 200 healthy women, aged 45 to 55 years, drawn from a statewide population of women residing in Australia.

Main Outcome Measure: The Women's Health Assessment Scale.

Results: Most frequently occurring perimenopausal symptoms included forgetfulness, lack of energy, irritability, and weight gain. The most distressing perimenopausal symptoms included weight gain, heavy bleeding, poor concentration, leaking of urine, and feeling as though life were not worth living.

Current use of hormone replacement therapy contributed to the prediction of both symptom occurrence and symptom distress.

Conclusion: Perimenopause is marked by more than hot flushes and night sweats; cognitive and affective changes are other distressing symptoms. The relationships between hormone replacement therapy use and both symptom occurrence and symptom distress warrant further investigation. In addition, practitioners should address concerns related to urinary incontinence, weight gain, cognitive and affective dysfunction, and general health status. JOGNN, 34, 21-27; 2005. DOI: 10.1177/0884217504272801

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Much has been written about menopause from a scientific perspective; however, little is known about individual experiences of hormone decline and the resulting perimenopausal symptoms (Hillard, 1998; Nachtigall, 1998). For the first time in history, most women in developed countries can expect to live 30 years beyond menopause. Even though the medical-scientific literature suggests that most women experience few major difficulties during perimenopause, this largely ignored and poorly understood period can be a critical time in a woman's life (Nachtigall, 1998). Estrogen decline can lead to vasomotor symptoms, decreases in bone density, urogenital discomfort, sexual dysfunction, irregular uterine bleeding (Sulak, 1996), psychological distress, and affective or cognitive disturbance (Lichtman, 1996; Schmid, Roca, Bloch, & Rubnaw, 1997; Sherwin, 1996). Building on the work of Li, Holm, Gulanick, Lanuza, and Penachofer (1997), this study aims to identify the most common perimenopausal symptoms experienced by a group of Australian women and explores the distressing nature of those symptoms.

Literature Review

A variety of terms are used to describe the time during which a woman moves from the reproductive to nonreproductive stage of her life. The climacteric or perimenopause are the names given to the transition as a whole (Rousseau, 1998). This stage is characterized by many complex biological, psychological, and sociocultural changes (Mas & Pattou, 1996; Rasmussen, 2000). Lasting on average 7 to 10 years (Rousseau, 1998) and spanning up to 25 years (Blackwell & Blackwell, 1997), perimenopause is
the time that estrogen levels decline, follicle-stimulating hormone (FSH) levels increase, and ovarian follicles are depleted (Nachigall, 1998; Sulak, 1996). Defined as "a few years before and one year after the permanent cessation of menses" (Li et al., 1997, p. 64), perimenopause is marked by FSH level >50 miU/ml (Bachmann, 1994). In developed countries, menopause (the final menstrual period) occurs at an average age of 51.3 years (MacLennan, 1997), and the years following the last menses are known as the postmenopause.

Perimenopause is frequently viewed from a biomedical perspective, and this ideology developed in the years following World War II (Li, Carlson, Snyder, & Holm, 1993). The advent of hormone replacement therapy (HRT) led to a concerted effort by drug companies and the medical profession to control perimenopausal symptoms. From a biomedical perspective, perimenopause is regarded as a sex-linked estrogen-deficient endocrinopathy (Li et al., 1995) and among health care professionals, a "treat just in case" mentality has become commonplace (Carlson, Li, & Holm, 1997, White & Schilling, 2000).

Unfortunately, this belief has led to perimenopause being considered a medical problem (Blackwell & Blackwell, 1997). Despite this, others portray this stage in a woman's life as a natural developmental phase (Berenhard & Sheppard, 1993) when an individual experiences many spiritual, cultural, and cognitive changes, not simply hormone decline (Li et al., 1995). Although attitudes and symptoms vary across cultures, many women have a social and cultural history that may determine their reactions to perimenopause (Li et al., 1995), and perimenopause can be both a positive and a negative biological and psychological experience.

Unique to each individual, symptoms may include menstrual pattern changes, vasomotor instability, cognitive and affective disturbances, sexual difficulties, and somatic manifestations (MacLennan, 1997; Nachigall, 1998). The most common perimenopausal symptom is altered menses; however, vasomotor instability, manifest by hot flushes, night sweats, and sleep disturbance, may impact negatively on one's sense of well-being (Greenfield et al., 1996; Hillard, 1998). In addition, cognitive and affective dysfunction (e.g., depression, irritability, mood swings, poor concentration, an inability to experience pleasure) during perimenopause may cause considerable distress to some women (McVeigh, 2000; Rohr, 2002; Schmidt et al., 1997). Coupled with somatic symptoms such as headache, dizziness, palpitations, and panic attacks; it is no wonder that some women feel out of control, think they are "going crazy" (McVeigh, 2000), and end up labeled complainers (Leidy, 1997).

When distressing symptoms occur, perimenopausal women have a variety of medical and nonmedical treatment options available to them. The judicious use of HRT may relieve climacteric symptoms (Nachigall, 1998; Rebar, Trabul, & Mortola, 2000), allow women to enter menopause with higher bone density (White & Schilling, 2000), and assist women with affective and cognitive disorders unrelated to other physiological imbalances (Li et al., 1997; McVeigh, 2000; Shepherd, 2001). In addition to HRT, bisphosphonates, raloxifene, and calcitonin may stabilize and improve bone mineral density (Eichner, Lloyd, & Timpe, 2003), and selective serotonin reuptake inhibitors may be a viable option for treating affective disorders during perimenopause (Stewart, 1998). However, caution is advised given the increased risk of osteoporosis attributed to SSRI administration (Goodnick, Chaudry, Artandi, & Arcey, 2000). Despite recent findings from the Women's Health Initiative (Writing Group for the Women's Health Initiative Investigators, 2002) and controversy within the Australian media about the efficacy of long-term hormone administration, HRT remains a good short-term treatment for severe perimenopausal symptoms (Dalley, 2002; Hillard, 1998). Although it is worth noting that postmenopausal women may also benefit from the use of HRT (Liedfeldt et al., 2002), the long-term use of HRT (i.e., >5 years) is not recommended (Dalley, 2002; Writing Group for the Women's Health Initiative Investigators, 2002).

Knowing that no single agent can treat perimenopausal symptoms as effectively as estrogen (Gass & Taylor, 2001), alternate treatment options for women who are either unwilling or unable to take HRT should be considered. A variety of complementary treatments are available (e.g., naturopathy, herbal medicine, homeopathy, osteopathy, massage, and traditional Chinese medicine). However, recent media attention in Australia suggests that complementary treatments may not have the effects promoted by advertisers. Evidence supporting the use of some nonprescription alternatives for conditions related to perimenopause is limited (Gass & Taylor, 2001; Kass-Amine, 2000). Information indicates that soy isoflavone (Hills, Soares, Hazel, de Lima, & Barreca, 2002), Evista (raloxifene), and Tiblone (Button, 1999) are the only alternatives proven through randomized controlled studies to increase bone density and offer some protection to the cardiovascular system. Due to the lack of research into the efficacy of herbal and naturopathic products, the over-the-counter availability of such therapies causes much concern within the Western medical community (Farrell, 1997; Gass & Taylor, 2001).

Even though women do have a choice, the choice is not simple. Although Button (1999) argues that the choice for women during perimenopause is between taking HRT and not taking HRT (i.e., long-term health versus functional decline), recent media released in Australia and the United States indicate that long-term use of combined
HRT may not be as safe as previously thought. Although Australian women aged 45 to 55 are faced with a difficult decision, little information is available concerning the most common perimenopausal symptoms and the level of distress experienced when symptoms occur. To address this shortfall and inform practice, the goal of this study was to gain a better understanding of the incidence of perimenopausal symptoms and explore the level of distress caused by these symptoms.

Design

Purpose and Methodology
This study identified the most common perimenopausal symptoms experienced by a group of Australian women using the Women's Health Assessment Scale and explored the level of distress caused by perimenopausal symptoms.

Sample
Drawing on previous Australian research (Dudley et al., 1998; Guthrie, Dennerstein, & Dudley, 1999), a nonrepresentative self-selecting convenience sample of 200 women aged 45 to 55 years, who were assumed to be perimenopausal, was drawn from a statewide population of women residing in New South Wales, Australia. All participants could read, write, and speak English and reported that they had no major medical problems that could contribute to the incidence of any symptoms.

Procedures
This study followed Australian National Health and Medical Research guidelines, and full ethics approval was received from the researcher's university and the health services participating in the project. All women's health centers listed with the New South Wales Women's Information and Referral Service were contacted in writing and invited to participate. These agencies were selected because they offered a health monitoring and support service to all women, were supported financially by the local health service, and could easily be accessed. Once access was approved, centers were provided with display posters and reply-paid registration forms. All women who expressed willingness to participate in this study by returning a registration form were provided with full details about the study, a questionnaire booklet, and a stamped self-addressed envelope for questionnaire return. Informed written consent was obtained. In addition, a snowball technique was employed, and registration forms were distributed through a variety of contacts at local and state conferences and workshops. Participants were asked to complete a general information form and the Women's Health Assessment Scale (WHAS; Li et al., 1999) on one occasion.

Instruments
A self-administered questionnaire was compiled specifically for this study and included the WHAS and a general information form. The general information form collected information about general demographics, menstrual history, reproductive history, and hormone utilization.

The symptoms associated with perimenopause were assessed using the WHAS. This 47-item tool was designed to measure four different aspects of perimenopausal symptoms: vasomotor, psychosomatic, menstrual, and sexual. In addition, it also measured the level of distress associated with symptoms. Frequency of symptoms experienced are measured on a 5-point Likert-type scale of 0 to 4 (0 = never, 1 = rarely, 2 = sometimes, 3 = often, and 4 = always). Level of symptom distress is similarly measured using a 5-point scale of 0 to 4 (0 = not at all, 1 = a little, 2 = moderately, 3 = quite a bit, and 4 = extremely). Both subscale and total scores are calculated, and Li et al. (1999) reported that the face and content validity of the WHAS was established through expert review; the Cronbach's alpha was calculated at .94 for the symptom scale and .91 for the distress scale.

Analyses
The analyses for this study were performed using SPSS (Statistical Package for the Social Sciences Version 11, SPSS, Inc., Chicago, IL) software. Frequency distributions and descriptive statistics were used to provide information about the sample, symptom frequency, and level of symptom distress. A standard multiple regression analysis was used to identify factors that contributed to the prediction of total symptom score and total distress score. In addition, t tests were employed to investigate differences in total scores based on the results that emerged from the regression analysis.

Results
In total, 24 women's health and menopause centers were contacted and invited to participate in the study. All but one of those agencies agreed to participate, and five additional centers contacted the researcher and requested that they be included in the study.

The Sample
Over a 12-month period, 200 healthy women aged 45 to 55 years registered for the project and were surveyed. In total, 80% (160/200) responded. The mean age was 49.5 years (SD 3.03, range 45-55 years), and 59%...
Most Distressing frequently occurring symptoms are displayed in Table 1, ity of the WHAS when used in this study was 25.91, range the time of a menstrual period, frightened/panicky nence. The mean total symptom score was 24 JOGNN were identified using the WHAS. The found weight gain to be the single most distressing of decrease in sexual desire or interest, a decrease in feeling In addition, almost three quarters (72%, 115/160) of the respondents experienced some degree of urinary disturbances, irregular bleeding). At the time of the survey, 70% (33/47) of those women were administering it in pill form. Most women (60%, 94/156) reported using complementary medicines in an effort to control perimenopausal symptoms.

Common Perimenopausal Symptoms

The most frequently occurring perimenopausal symptoms were identified using the WHAS. The 10 most frequently occurring symptoms are displayed in Table 1, and they included weight gain, lack of energy, irritability, poor concentration, weight gain, nervousness, a decrease in sexual desire or interest, a decrease in feeling of well-being, early morning awakenings, and hot flushes. In addition, almost three quarters (72%, 115/160) of the respondents experienced some degree of urinary incontinence. The mean total symptom score was 60.71 (SD 25.91, range 8-145), and the internal consistency reliability of the WHAS when used in this study was 0.92 for the symptom scale and 0.93 for the distress scale.

Most Distressing Symptoms

Symptoms such as weight gain, excessive bleeding at the time of a menstrual period, frightened/panicky feelings, leaking of urine, poor concentration, and irritability were some of the most distressing symptoms experienced by the participants. More than 86% (115/134) of women found weight gain to be the single most distressing symptom they experienced. Hot flushes were not one of the top 10 most distressing symptoms identified in this study. The mean total score for most distressing symptoms was 54.8 (SD 29.6, range 2-142). Full details of level of distress experienced are displayed in Table 2.

Cognitive and affective symptoms occur frequently during perimenopause.

Regression Analyses

A standard multiple regression analysis showed that together, age, past history of menstrual problems, history of problems following the withdrawal of oral contraceptives (OCPs), and current use of HRT accounted for 13% of total variance in symptom score, which is highly significant as indicated by the F value (F = 4.290, df/4, p = .003). An examination of the t values indicated that both age (t = -2.109, p = .037) and current HRT use (t = 2.373, p = .019) contributed to the prediction of total symptom score.

Similarly, the regression analysis showed that together, these same four factors (i.e., age, past history of mensturalal problems, history of problems following the withdrawal of OCPs, and current use of HRT) contributed to 11% of the variance in total distress score, which is highly significant as indicated by the F value (F = 3.482, p = .01). An examination of the t values indicates that only current HRT use (t = 2.041, p = .043) contributed to the prediction of total distress score.

When women who were currently taking HRT were compared with women who were not currently taking HRT, those taking HRT scored higher for all subscale and
The aim of this study was to identify the most common perimenopausal symptoms experienced by a group of Australian women and explore the distressing nature of those symptoms. Although the literature reports altered menses and hot flushes as the most common perimenopausal symptoms (Nachigall, 1998), the women in this study found forgetfulness, lack of energy, irritability, poor concentration, and weight gain occurred more frequently than those symptoms usually attributed to perimenopause. The reality for most of these women was that 8 of the 10 most frequently occurring symptoms were psychosomatic in nature, not menstrual or neurovascular. Although menstrual pattern disturbance and hot flushes did occur, they did not occur as often as one would expect based upon the literature.

Interestingly, the most distressing symptom reported was weight gain. One hundred thirty-two women experienced this problem, and 86% found weight gain to be from moderately to extremely distressing. Similar to symptom occurrence, 8 of the 10 most distressing symptoms were also psychosomatic in nature. Although it is unclear why this occurred, it may be related to a decrease in naturally occurring hormones and the effect this decrease has on the brain. These findings support the notion that estrogen decline can lead to affective and cognitive distress (Lichtman, 1996; McVeigh, et al., 1997). As previously stated, such changes may result in some women feeling out of control (McVeigh, 2000) and being labeled complainers (Leidy, 1997).

Although not originally anticipated, the positive relationship identified between HRT use and both symptom occurrence and distress is of great interest. Why women currently taking HRT were more symptomatic and distressed than women not on HRT is unclear. Although these results may suggest that some women on HRT were simply more symptomatic prior to treatment, it may also indicate that, once prescribed hormone supplementation, they were inadequately monitored and the form or dose of HRT was inappropriate to their needs. The situation reported here may also place some women at risk of abandoning their treatment and placing themselves at risk of greater psychological difficulty due to withdrawal symptoms (Huber et al., 1999; McVeigh, 2000; White & Grant, 1998). Although the extent to which HRT use predicted symptom occurrence and distress was limited, fur-

<table>
<thead>
<tr>
<th>Symptom (n)</th>
<th>Not at All</th>
<th>Slightly</th>
<th>Moderately</th>
<th>Quite a Bit</th>
<th>Extremely</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight gain (134)</td>
<td>5 (4)</td>
<td>14 (10)</td>
<td>29 (22)</td>
<td>41 (31)</td>
<td>45 (33)</td>
</tr>
<tr>
<td>Excess bleeding (73)</td>
<td>5 (7)</td>
<td>10 (14)</td>
<td>21 (29)</td>
<td>22 (28)</td>
<td>15 (20)</td>
</tr>
<tr>
<td>Frightened/Panicky (79)</td>
<td>5 (6)</td>
<td>19 (24)</td>
<td>23 (29)</td>
<td>22 (28)</td>
<td>10 (13)</td>
</tr>
<tr>
<td>Leaking of urine (113)</td>
<td>5 (4)</td>
<td>31 (27)</td>
<td>31 (27)</td>
<td>24 (22)</td>
<td>22 (20)</td>
</tr>
<tr>
<td>Lack of energy (143)</td>
<td>10 (7)</td>
<td>34 (24)</td>
<td>42 (29)</td>
<td>38 (27)</td>
<td>19 (13)</td>
</tr>
<tr>
<td>Poor concentration (137)</td>
<td>5 (4)</td>
<td>39 (29)</td>
<td>28 (20)</td>
<td>37 (27)</td>
<td>28 (20)</td>
</tr>
<tr>
<td>Irritability (138)</td>
<td>6 (4)</td>
<td>44 (32)</td>
<td>43 (31)</td>
<td>25 (18)</td>
<td>20 (15)</td>
</tr>
<tr>
<td>Life not worth living (57)</td>
<td>6 (11)</td>
<td>15 (26)</td>
<td>11 (19)</td>
<td>10 (18)</td>
<td>15 (26)</td>
</tr>
<tr>
<td>Forgetfulness (144)</td>
<td>7 (5)</td>
<td>46 (32)</td>
<td>27 (19)</td>
<td>37 (23)</td>
<td>27 (19)</td>
</tr>
<tr>
<td>Difficulty falling asleep (104)</td>
<td>13 (13)</td>
<td>29 (28)</td>
<td>21 (20)</td>
<td>22 (21)</td>
<td>19 (18)</td>
</tr>
</tbody>
</table>

**Total symptom scores.** Differences for vasomotor (t = 2.782, df 152, p = .0001), psychosomatic (t = 3.600, df 149, p = .0001), sexual (t = 2.392, df 122, p = .018), and distress scores (t = 4.085, df 154, p = .0001) were significant. In addition, women currently taking HRT also scored higher for all distress subscale and total distress scores. Scores for vasomotor (t = 2.912, df 73, p = .003), psychosomatic (t = 3.692, df 154, p < .0001), sexual (t = 2.355, df 127, p = .02), and total distress (t = 4.099, df 154, p < .0001) were significant. Finally, when women aged 50 years or older were compared with the younger women in this study, they scored significantly higher for the incidence of vasomotor symptoms (t = -3.011, df 156, p = .003). No other significant differences in symptom or distress scores were noted based on age.

**Discussion**

The most distressing perimenopausal symptoms experienced by a group of Australian women and the distressing nature of those symptoms. Although the literature reports altered menses and hot flushes as the most common perimenopausal symptoms (Nachigall, 1998), the women in this study found forgetfulness, lack of energy, irritability, poor concentration, and weight gain occurred more frequently than those symptoms usually attributed to perimenopause. The reality for most of these women was that 8 of the 10 most frequently occurring symptoms were psychosomatic in nature, not menstrual or neurovascular. Although menstrual pattern disturbance and hot flushes did occur, they did not occur as often as one would expect based upon the literature. Interestingly, the most distressing symptom reported was weight gain. One hundred thirty-two women experienced this problem, and 86% found weight gain to be from moderately to extremely distressing. Similar to symptom occurrence, 8 of the 10 most distressing symptoms were also psychosomatic in nature. Although it is unclear why this occurred, it may be related to a decrease in naturally occurring hormones and the effect this decrease has on the brain. These findings support the notion that estrogen decline can lead to affective and cognitive distress (Lichtman, 1996; McVeigh, et al., 1997). As previously stated, such changes may result in some women feeling out of control (McVeigh, 2000) and being labeled complainers (Leidy, 1997).

Although not originally anticipated, the positive relationship identified between HRT use and both symptom occurrence and distress is of great interest. Why women currently taking HRT were more symptomatic and distressed than women not on HRT is unclear. Although these results may suggest that some women on HRT were simply more symptomatic prior to treatment, it may also indicate that, once prescribed hormone supplementation, they were inadequately monitored and the form or dose of HRT was inappropriate to their needs. The situation reported here may also place some women at risk of abandoning their treatment and placing themselves at risk of greater psychological difficulty due to withdrawal symptoms (Huber et al., 1999; McVeigh, 2000; White & Grant, 1998). Although the extent to which HRT use predicted symptom occurrence and distress was limited, fur-

<table>
<thead>
<tr>
<th>Level of Distress (%)</th>
<th>Not at All</th>
<th>Slightly</th>
<th>Moderately</th>
<th>Quite a Bit</th>
<th>Extremely</th>
</tr>
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**Women taking HRT had significantly higher symptom and distress scores than women not taking HRT.**

**Total symptom scores.** Differences for vasomotor (t = 2.782, df 152, p = .0001), psychosomatic (t = 3.600, df 149, p = .0001), sexual (t = 2.392, df 122, p = .018), and distress scores (t = 4.085, df 154, p = .0001) were significant. In addition, women currently taking HRT also scored higher for all distress subscale and total distress scores. Scores for vasomotor (t = 2.912, df 73, p = .003), psychosomatic (t = 3.692, df 154, p < .0001), sexual (t = 2.355, df 127, p = .02), and total distress (t = 4.099, df 154, p < .0001) were significant. Finally, when women aged 50 years or older were compared with the younger women in this study, they scored significantly higher for the incidence of vasomotor symptoms (t = -3.011, df 156, p = .003). No other significant differences in symptom or distress scores were noted based on age.

**Discussion**

The aim of this study was to identify the most common perimenopausal symptoms experienced by a group of Australian women and explore the distressing nature of those symptoms. Although the literature reports altered menses and hot flushes as the most common perimenopausal symptoms (Nachigall, 1998), the women in this study found forgetfulness, lack of energy, irritability, poor concentration, and weight gain occurred more frequently than those symptoms usually attributed to perimenopause. The reality for most of these women was that 8 of the 10 most frequently occurring symptoms were psychosomatic in nature, not menstrual or neurovascular. Although menstrual pattern disturbance and hot flushes did occur, they did not occur as often as one would expect based upon the literature. Interestingly, the most distressing symptom reported was weight gain. One hundred thirty-two women experienced this problem, and 86% found weight gain to be from moderately to extremely distressing. Similar to symptom occurrence, 8 of the 10 most distressing symptoms were also psychosomatic in nature. Although it is unclear why this occurred, it may be related to a decrease in naturally occurring hormones and the effect this decrease has on the brain. These findings support the notion that estrogen decline can lead to affective and cognitive distress (Lichtman, 1996; McVeigh, et al., 1997). As previously stated, such changes may result in some women feeling out of control (McVeigh, 2000) and being labeled complainers (Leidy, 1997).

Although not originally anticipated, the positive relationship identified between HRT use and both symptom occurrence and distress is of great interest. Why women currently taking HRT were more symptomatic and distressed than women not on HRT is unclear. Although these results may suggest that some women on HRT were simply more symptomatic prior to treatment, it may also indicate that, once prescribed hormone supplementation, they were inadequately monitored and the form or dose of HRT was inappropriate to their needs. The situation reported here may also place some women at risk of abandoning their treatment and placing themselves at risk of greater psychological difficulty due to withdrawal symptoms (Huber et al., 1999; McVeigh, 2000; White & Grant, 1998). Although the extent to which HRT use predicted symptom occurrence and distress was limited, fur-
their investigations are needed to improve our understanding of why this relationship exists.

Limitations

The generalizability of the results may be limited by the sampling techniques employed, and bias may have occurred because only women attending women's health and menopause services were surveyed. In addition, although the sample was drawn from a statewide population, it may not be representative of the general population of perimenopausal women. Had the sample been larger and included non-English-speaking women and women from distinct cultural groups, and had the women been randomly selected, the results may have been different. Future research should address these limitations and focus on the needs of women during perimenopause. Despite these limitations, a response rate of 80% was acceptable, and the findings highlight a number of important issues, including the level of cognitive and affective distress experienced by some women; the relationship between HRT use and symptoms occurrence and distress are noteworthy.

PRACTITIONERS SHOULD ASSESS THE TOTAL NEEDS OF THEIR PERIMENOPAUSAL CLIENTS.

Recommendations

Perimenopause is marked by more than hot flushes and night sweats. Cognitive and affective disturbance, most specifically forgetfulness, irritability, nervousness, poor concentration, and a general decrease in one's sense of well-being, also cause considerable distress during this period of time. Clearly, further in-depth research is needed to improve our understanding of the results that emerged from this study. Although the relationship between hormone replacement therapy use and symptom occurrence and distress warrants further investigation, other factors should be considered when assessing the needs of perimenopausal women. As a priority, future research should explore the relationship between the distress caused by perimenopausal symptoms and quality of life. While we await the results of future studies, practitioners should offer programs aimed at minimizing urinary incontinence, limiting weight gain, reducing cognitive and affective dysfunction, and improving general health status. The close monitoring of clients during the early months of treatment with HRT may also be prudent.

Acknowledgment

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REFERENCES


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