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<b>Authors(s)</b>	Hyde, Abbey, Nee, Jean, Drennan, Jonathan, Butler, Michelle, Howlett, Etaoine
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## **HT AND THE MEDICAL ENCOUNTER: A QUALITATIVE ANALYSIS OF WOMEN'S EXPERIENCES**

[abbey.hyde@ucd.ie](mailto:abbey.hyde@ucd.ie)

**Keywords:** Menopause; doctor-patient encounters; hormone therapy; women's health.

## **HT AND THE MEDICAL ENCOUNTER: A QUALITATIVE ANALYSIS OF WOMEN'S EXPERIENCES**

### **Abstract**

*Objective:* The aim of this article is to explore women's experiences in biomedical consultations for menopause symptoms, with a particular focus on how Hormone Therapy (HT) featured during the encounter. *Methods:* Semi-structured interviews were conducted with 39 women and data were analysed using a qualitative strategy referred to as Thematic Networks. *Results:* Several participants whose menopause started before the period of the HT 'scares' described being 'put on' HT as a matter of course, even where their symptoms were mild. By contrast, some of those presenting in the more recent time period with what they deemed to be severe symptoms were more likely to describe scenarios whereby they pressured their doctors for a HT prescription. Once on HT, participants were found to be far from passive recipients of a biomedical

'treatment' but rather embarked on an active dialogue with themselves about how to manage distressing aspects of the menopause. *Conclusion:* that using HT did not tend to spell a transition to biomedical advocacy, in spite of its reported effectiveness in moderating bodily distresses. Rather, HT tended to retain a tentative status as temporary relief, and not a long-term panacea.

**Keywords:** Menopause; qualitative; doctor-patient encounters; hormone therapy; women's health.

## **Introduction**

This article focuses on women's experiences in seeking the assistance of biomedical doctors for menopause symptoms, particularly in relation to how Hormone Therapy (HT) is considered during medical encounters, given its prominence in recent decades in discourses that elucidate the biomedical 'treatment' of the menopause. The paper focuses on identifying the discourses that mediated the accounts of a sample of women in Ireland in describing their help-seeking behaviour for menopausal symptoms, and how they made sense of the courses of action open to them. As will become clear in the next section, there are existing studies on this topic internationally. Nonetheless, this new study was deemed to be worthwhile because the landscape with regard to biomedical perspectives on the safety of HT has shifted over the past decade, changing the context in which HT is negotiated, prescribed and managed. Interpretative research always holds the promise of offering new theoretical insights into understanding an issue, as it is premised on the notion that reality is socially produced in specific social contexts and may be viewed through a different conceptual lens at different points in time. As indicated, the context of

the study in this case was Ireland, and while it is acknowledged that meanings and experiences associated with the menopause can vary culturally, findings from this study are likely to be of relevance to health researchers and practitioners in other Western societies. In addition, this study builds upon a growing genre of work on menopause internationally.

## **Background**

Hormone Therapy (HT) combination products (oestrogen and progestin) were introduced in the 1980s, after oestrogen therapy fell out of favour in the mid-70s when it was found to increase the rates of endometrial cancer 8-fold. The use of these products however, was seriously called into question by two seminal studies in 1998 and 2002/4 – the Heart and Estrogen/Progestin Replacement Study (HERS) and the Women’s Health Initiative (WHI). Collectively, these research findings provided the first comprehensive evaluation of the outcome of long-term hormone therapy (National Institutes of Health, 1998). Prior to the publication of HERS in 1998, postmenopausal women were recommended to consider taking HT based on the diversity of beneficial effects it was purported to provide. Such women began to be recognised as being subject to an increased risk of osteoporosis and heart disease, with HT playing a significant role in the prevention of such diseases (Ballard 2002).

In 2002, four years after the publication of HERS, the primary prevention properties of HT in terms of coronary heart disease again ‘came under crossfire’ when the first data from the WHI was made public, indicating negative outcomes (Pines, 2007:1). According to Hulley and Grady (2004), the net harm index was markedly accentuated by a later report of a 2-fold increase in the incidence of dementia among those over 65 years in the WHI research. A further major

study, recently published in *The Lancet*, has added to the emerging 'scare' response in revealing an increased risk of ovarian cancer among HT users (Beral et al, 2007).

A Scandinavian study (Lindh-Åstrand *et al.* 2007) has attempted to capture if new findings emerging in the various biomedical trials were changing women's attitudes towards HT. To this end, the authors explored changes in Swedish women's attitudes towards HT between 1999 and 2003 with 1,760 questionnaires administered in 1999 (74% response rate) and 1,733 in 2003 (77% response rate). In terms of actual HT usage, significantly fewer women (17%) in 2003 believed that all women should use HT, compared with 37% from the 1999 cohort. About 75% of women from both cohorts agreed (totally or somewhat) that women with significant symptoms should use HT. However, this proportion was influenced by usage of HT. For instance, while most users of HT (92% in 2003) agreed that women with symptoms should use HT, only 67% of non-users did. Thirty-four percent of HT users in the 2003 cohort believed that *all* women should use HT, regardless of the degree of symptoms they experienced (Lindh-Åstrand *et al.*, 2007). However, between 1999 and 2003, the authors also found that the number of current users of HT fell from 40% to 25%. The number of never users increased from 48% to 56% over the same period. This decline in the usage of HT was accompanied by an increase from 10% in 1999 to 18% in 2003 in the number of women in Sweden exploring the use of complementary therapy to relieve menopausal symptoms (Hoffmann *et al.*, 2005).

Let us move on to consider some existing qualitative analyses on how women perceive HT. Constructions of HT appear to be related to how women define the menopause, ie, whether they view primarily as a hormone deficiency in need of treatment, or as a natural process to be managed without biomedical intervention. Stephens et al (2002), using focus group data from 48 participants

in a New Zealand setting, explored the varying discourses utilised in creating participants' understanding of the menopause. One dominant concept used by women was the construction of the menopause as a time of *threatening change*, characterised by undesirable changes beyond their control, with HT constructed as a useful mechanism to control physiological concerns. In addition, women drew on the *biomedical* discourse which enabled them to utilise medical terms (i.e. symptoms, hormones, sides effects, risks) to describe their experiences of the menopause. The *drug* discourse, incorporating as it does negative images from recreational drug use such as 'pill popper' and 'dependence', was often drawn on by participants to oppose the use of pharmaceuticals such as HT. The *natural* discourse was used to redefine the construction of the menopause as a time of *threatening change*, and similarly to resist the use of artificial synthetic hormones, with HT constructed as unnatural, and by corollary, unhealthy (Stephens *et al*, 2002:351-353).

Other research has elucidated how women's perceptions of the menopause and HT are not fixed. Of the 45 women interviewed by Hunter *et al* (1997) in a British context, just seven were taking HT at the time of the research. When asked about their decision-making processes in relation to HT, a commonly mentioned theme was to question whether it is 'natural' to take medication for the menopause, prompting concerns about disturbing the natural rhythm of their cycles. However, neither this notion of naturalness, nor the menopause itself, was a static concept. Where women experienced significant symptoms and problems, the menopause migrated from being a 'natural process' into the realm of illness and disease, and therefore became a legitimate target for treatment (Hunter *et al*, 1997: 1546). Similarly, Morris and Symonds (2004), in their British study, found that women utilise a range of alternative discourses on the menopause, including notions of 'naturalness', prompting them to seek remedies from

homeopathy, diet and other forms of alternative therapies, alongside any medically-based assistance they might utilise.

## **Research design**

Findings presented in this paper focusing on women's experiences of help-seeking for menopausal symptoms, particular in relation to HT, are part of a wider study of women's experiences of the menopause in an Irish context. Participation in the study was open to women who defined themselves as menopausal at the time of recruitment to the study, or who perceived themselves to be such up until the previous year, regardless of whether they had ever sought help for symptoms. Ethical approval for the study was processed through the Ethics Committee at the university at which the research was conducted.

A selection of women's organisations was selected purposively from those listed as associations affiliated to the National Women's Council of Ireland. Organisations were specifically targeted that were likely to engage with women in their midlife years, and were based in both rural and urban locations in the Republic of Ireland. The nature of the work of the organisations was considered when identifying those to contact, in order to attract women with diverse life experiences and from a range of socio-economic groups. A letter was sent to the selected organisations, and followed up with a telephone call for the purposes of achieving personal contact and enhancing the level of recruitment. In total, 23 participants were recruited from 8 different organisations (23 organisations were approached to achieve this degree of success). In addition, an established sampling technique called *snowball sampling* was used, whereupon participants recruited through the organisations were asked to identify others whom they

believe to be suitable participants for the study. Snowball sampling yielded 12 women, while one further participant was recruited via the Women's Health Council. Finally, 3 additional women were selected via a Traveller organisation (nomadic Irish ethnic minority group), yielding a total for the study as a whole of 39 participants. For an overview of characteristics of the sample, see Table 1.

**Table 1. Characteristics of the sample**

<b>Marital status</b>	<i>Married</i>	<i>Single (never married)</i>	<i>Previously married (Separated/Divorced/Widowed)</i>	<i>Co-habiting same sex relationship</i>
	n=25 (64%)	n=3 (7.7%)	n=3 (7.7)	n=8 (20.5%)
<b>Employment status</b>	<i>In paid employment</i>	<i>Not in paid employment</i>		
	n=17 (43.5%)	n=22 (56.5%)		
<b>HT use</b>	<i>Previously used HT</i>	<i>Currently using HT</i>	<i>HT contraindicated on medical grounds</i>	<i>HT neither contraindicated nor used</i>
	n=10 (25.7%)	n=4 (10.2%)	n=11 (28.2%)	n=14 (35.9%)
<b>Socio-economic status</b>	<i>Socioeconomic Group 1-3 (Professional, non-manual)</i>	<i>Socioeconomic Group 4-6 (Manual)</i>	<i>Traveller (Ethnic minority group)</i>	
	n=18 (46.15%)	n=18 (46.15%)	n=3 (7.7%)	
<b>Age range of participants</b>	<i>40-44</i>	<i>45-49</i>	<i>50-54</i>	<i>55-59</i>
	n=5 (12.8%)	n=6 (15.4%)	n=12 (30.8%)	n=11 (28.2%)
<b>Rural/Urban status</b>	<i>Rural</i>	<i>Urban</i>	<i>Nomadic</i>	
	n=17 (43.6%)	n=19 (48.7%)	n=3 (currently urban) (7.7%)	

It should be noted that whilst the inclusion of lesbian and Traveller women in the study was deliberate since these groups are often marginalised in research, qualitative studies of this type do not usually strive for representative sampling. Nonetheless, in a number of respects the sample loosely reflects social distinctions more broadly within Ireland. For example, at the time of data

collection, 49% of women in Ireland were in paid employment (Central Statistics Office 2008) and the bulk of women of this age group were married. (The 2006 Census of Population indicated that 71% of women aged 40-69 years were married; 13% were single (never married); 11% either separated or divorced; and 5% widowed (Central Statistics Office 2007a).) There was a good mix of socio-economic groups in the sample, although it is difficult to determine whether participants' socio-economic status mirrored that of the women in the population at a national level, because the most recent census data (gathered in 2006) indicating women's SEG in Ireland shows that a third of the female population are allocated to a generic SEG category that includes the descriptor 'unknown' (Central Statistics Office 2007b). Participants' ages ranged from 42-63 years, with a mean age of 53.5 years.

Data were gathered by means of semi-structured interviews during 2007, and all apart from one were individual interviews. The exception was a focus group with three Traveller women, who expressed a preference to be interviewed together. Interviews were audio-recorded and later transcribed, and the average length of each was 50 minutes. Data were then analysed using 'thematic networks' (Attride-Stirling 2001), a pragmatic strategy for analysing qualitative data that draws on earlier developments such as grounded theory (Glaser and Strauss 1967) and argumentation theory (Toulmin 1958). It involves the construction of *thematic networks*, that is, 'web-like illustrations (*networks*) that summarise the main *themes* constituting a piece of text' (Attride-Stirling 2001: 386). The process of analysis was as follows (i) extracting *basic themes* of the lowest order variety; (ii) drawing together basic themes to more abstract *organising themes*; and (iii) *constructing* macro themes that brought together lower-order themes.

In keeping with established practices in qualitative research, data analysis for this study began as soon as the first few interviews were completed, and continued throughout the data collection phase. Data analysis was facilitated by use of the software package NVivo, which allowed a large volume of data to be organised. However, care was taken to avoid extracting quotations from their context. In addition, a more refined theoretical analysis also occurred in order to illuminate what was going on in data in relation to the wider social context. This is consistent with the interpretative strategy of thematic networks. Rigour was maintained by several members of the research team reading transcripts and discussing a range of possible interpretations in instances where there were inconsistencies and contradictions in the participant's line of thinking.

## **Results**

### **Biomedical encounters and interventions**

While not all study participants went to the doctor with bodily distresses associated with the menopause, the vast majority (30 out of the 39 – almost 77%) did. Distressing bodily experiences that were at variance with participants' usual sense of well-being were what prompted most women to seek medical help, irrespective of whether or not they associated these bodily vicissitudes with the menopause prior to the consultation (which the majority did). However, there were other situations where participants consulted because they felt unwell and were 'diagnosed' with the menopause. The very notion of whether or not women's distresses were related to the menopause was contested by the doctor in 5 cases (this is the subject of a separate publication (Author et al (accepted for publication))). Interestingly, there were no reports of participants contesting a physician's judgement that their bodily aberrations were menopause-related, that is, there was no case of resistance to the menopause label.

Where distresses were affirmed by the doctor as menopause-related, a central feature of the encounter was the dominance of HT in the discussion between the participant and the physician, including in those situations where its use was contraindicated on medical grounds. (A number of women could not consider using HT, 4 because of their own cancer diagnosis, and a further 7 because they had been diagnosed with other disorders or had a family medical history that contraindicated its use.) Whilst in some cases HT was rapidly dismissed by both parties (doctor and woman) as a possible option, the fact that HT was presented as the *only* remedy for menopause-related distresses was the single most dominant grievance among participants about such encounters, an issue that we will expand upon a little further on.

The data identified a shift in the prescribing of HT that occurred after the publication of studies highlighting risks associated with it. While just 4 of the 39 women were taking HT at the time of the interviews, 10 additional women had previously used it. Three of the four women taking HT at time of the interviews had been using it for at least 9 years, with one participant taking it for 18 years. One woman noted how her first HT combination did not suit her, but later was prescribed a more agreeable version.

Even in the period before the 'scares', some women were cautious about the use of HT and actively resisted it as a treatment option, as the following quotation indicates.

He [doctor] suggested I go on HRT [Hormone Replacement Therapy] and I said, 'No I would be afraid it would give me cancer,' and rightly enough the doctor said 'It won't give you cancer.' I didn't go on it, He thought that would sort me out because I was going to him and he kept saying that I was depressed. I didn't, I said 'No, I don't want to put anymore chemicals into my body.' Just my GP saying to go on HRT and it would

be good for your bones and give yourself two years. And I just was nervous of it. . . He suggested it a couple of times.... [P.27]

However, apart from the few who described instances of such resistance, most women who were prescribed HT in the period prior to the negative trial results described being 'put on' HT, often with very little discussion.

I didn't get a lot of advice on it, but it was felt that women should go on HRT when they came to the menopause, what was it, because of the heart thing ...[P.30]

I was on HRT for a while.

Int: Were you, yeah? You know you were saying that you had night sweats but you didn't have the flushes and the [interrupted].

I think he was one of these doctors that just put you on it. [P.33]

In the period since then, by contrast, descriptions of discussions during biomedical consultations paint a different picture, with the women being much more likely than the doctor to be the one pressing for a HT prescription.

I struggled, for a year, maybe eighteen months. I finally went to the doctor and said 'Look! You have to do something for me here, [uncomfortable laugh] I just cannot go on.' [P.16]

I actually said to the doctor when I asked him. . . He was telling me all the bad things about it [HT] and I was telling him all the good things I had heard from friends, that I won't be creaking and aching, my headaches will go, I'll know what my middle name is! And a full night's sleep with it! [P.15]

Then the hot flushes started and they were just awful. It was like every half an hour. . . . All my life I've been into alternative medicine, and I just went straight to the doctor and said, 'Give me the pills!' [P.4]

Participants' orientation towards a particular discourse very often did not translate into practice, with some of the strongest advocates of Complementary and Alternative Medicine (CAM) strongly soliciting doctors to prescribe HT for them. Those participants who had taken, or were currently taking HT virtually always (with a few exceptions) presented a justification to the researcher as to why they were taking it and simultaneously conveyed their own sense of disapproval of HT. Some outlined their biographical scepticism of biomedicine (for example, by expositions such as 'throughout my life, I'd never take a tablet . . .'), which collapsed in the face of a dwindling quality of life and in many cases, associated feelings of desperation.

### **The tentative status of using HT**

Dependency on HT to mask symptoms that would resurface should one discontinue its use also concerned women who were using it, and made them uneasy about using it long-term. Three of the 4 women on HT at the time of the interviews stated that they would like to replace it with CAM. Most participants who had used HT in the past, or who were at the time of the interviews receiving HT, had engaged or were engaging in an active process of deliberation about how long its use should continue. This involved assessing their circumstances, weighting up when they would be ready to dispense with it, and balance the severity of the distress associated with menopausal bodily changes against serious side-effects of HT such as the risk of breast cancer. The vast majority of participants in this category (current or past HT users) were far from passive recipients of a biomedical 'treatment' but rather embarked on an active dialogue with themselves about how to manage distressing aspects of the menopause. Being on HT was thus characterised as a tentative status necessitating re-examination and self-appraisal of circumstances to determine when and how one might discontinue its use. The agency of participants in decisions about the use of

HT, such as in assessing when and how it was required, is evident in the case of one woman who took HT intermittently and for very short periods (such as one month) to tide her over bouts of severe distress.

That's why I wouldn't like to stay on it completely, because I want it [menopause] over with. I'd like to finish the periods. I want to go through what I have to go through. But if I am very severe, I would just take it - even if it is only for a month. And two years later, maybe for another month or whatever. I don't really like taking it because wouldn't like to have the problems that it might cause. [P.6]

Another case in point is that of a participant who engaged in a process of circumspection about when to discontinue HT. She started HT and anti-depressants at a time of considerable stress in her life, and actively assesses her readiness to take the step to discontinue HT.

Having done the counselling I feel I could handle it all a lot better. And being in an environment where I'm not on public display [participant was a teacher]. And not having to think on my feet. And not in a pressured environment . . . What I'd do is stay on the anti-depressants and gradually come off the HRT. But I want to do that with an alternative practitioner lined up, because there are so many options. You just...it's hard to know. [P.4]

Another participant felt more ready to dispense with HT after 4 years of its use, when the more upsetting events in her life had relented somewhat.

There was a lot to get over. And it had been a year of three deaths, so I had a lot to deal with really. And I got really low about it. I absolutely wanted to make the symptoms go away, so I went to my doctor who was highly sympathetic and put me on HRT. . . so I was probably on it for about four years . . . Anyway, I had to tail off slowly, but actually the symptoms came back. But then I was in a better space in my head, I think. [P.8]

One woman used her sister as a reference point, noting that the latter had remained on HT into later old age without developing the serious side-effects.

These narratives suggest that starting and stopping HT involved a process of decision-making by the women themselves. Commencing HT tended to be underpinned by feelings of desperation and an inability to function as usual in one's social role and the need for immediate relief. Once on HT, the decision about how it would be managed (maintained, used intermittently or discontinued) involved a more complex and protracted cognitive process for women in which they brought to bear a range of circumstantial and temporal issues.

Those who had used, or at the time of the interview were using, HT almost all found that their aberrant bodily experiences were relieved within days of commencing it, although some women found that while it countermanded their physical malaise, the psychological ones continued. A few women associated weight gain, increased forgetfulness and the growth of dark hairs on the face with using HT. Those who stopped HT found that their symptoms returned when they discontinued its use, although a few mentioned that one or other aberration such as headaches or night sweats did not reoccur. Only a couple of women who had been prescribed HT prior to the negative clinical trial results and whose bodily experiences were only mildly distressing noted no difference in their symptoms with the use of HT.

### **Medical consultations: a biomedical focus**

Perhaps the most consistent criticism of consultations with the medical profession voiced by women in the study was the lack of suggestions of any alternatives to

HT for menopause symptoms. This came from participants across the sample from both working and middle-class backgrounds. One woman who had, in the period prior to 'the scares', attended a female doctor widely known as a woman's health specialist, was most disappointed that the only countermeasure proposed to manage symptoms was a biomedical one.

P1: And she was writing out the prescription for HRT as I was speaking, virtually. . . . So I said to her, 'What do you recommend as kind of natural remedies, and diet and exercise?' And she had no clue. But also, it's the frustration around GPs, really. They should know better than just to see this as an HRT issue and nothing else. So I would have thought that she would have been better informed about alternative therapies, or just the link with diet and exercise actually. . . . I think GPs need to be better informed about how symptoms can be treated. [P.1]

Although a few women were advised about aspects of diet that exacerbated or alleviated symptoms, and were given brief information about substitutes, the majority were not. One participant was satisfied with her medical interactions because her GP was also a herbalist. However, several participants reported being dissatisfied with the lack of alternatives if HT as an option was discounted. However, others brought to the encounter an expectation that medical practitioners would not have a knowledge of CAM.

Most GPs wouldn't know very much about natural remedies if you asked them anyway because they are not into that anyway. [P.26]

One participant who was 'put on' HT 7 years prior to the interview, but 'taken off' HT subsequent to the negative research results, recalled a discussion about CAM with her GP in which the latter indicated her reluctance to advise on CAM in the absence of an evidence basis for its effectiveness. As indicated in the participant's recollection of the encounter, CAM was a matter external to the jurisdiction of biomedicine and left to the women themselves to both access and assess.

She did, she was very good, she said ... like I was talking about alternative HRT and she said, 'There is really no study into the alternative HRT to be honest. It is up to yourself if you want to use it. What I have, there has been studies on and how it affects you.'  
So she did bring me through it. [P.18]

Another participant reported that 'a few doctors in the town' had highlighted the 'dangers of soya products',<sup>1</sup> although she herself found them to be effective.

While many women found their GPs helpful and pleasant, others found themselves dismissed and unsupported. One participant stated that she received more support from the assistant at the health shop than from her GP. Moreover, some participants indicated that, HT or no HT, their doctors appeared to have very little knowledge and understanding about the menopause.

## **Discussion and conclusion**

It is worth noting that although every effort was made to capture a range of experiences, it is very likely that there is an over-representation in the study of those women who experienced a difficult menopause, because participation in a study of this type might appeal to a greater extent to such women. While some participants described an uneventful menopause, with none or few distressing symptoms, as indicated, almost 77% of participants had consulted a doctor specifically in relation to their menopause. This is a higher proportion than was found in the Hvas *et al* (2003) large study of GP provision in Denmark, which

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<sup>1</sup> As in all studies of this kind, there may be some factual inaccuracies in the statements made by participants and in the information they received from others or their interpretation of this information. Soya products contain phyto-oestrogens which are believed to possibly relieve symptoms by mimicking the effects of oestrogen in the body. The 'dangers' referred to here may relate to a possible 'oestrogen' effect of soya, for example, in the context of certain cancers, or the potential damage to bone health if soya products are substituted for richer calcium sources, such as dairy products, in the diet.

found that just over two-thirds of their participants had discussed the menopause with a doctor. A second limitation of the study is that since most participants were recruited to the study via women's groups and organisations, there appeared to be a higher than expected proportion of working-class women with a good level of literacy about their bodies, and a good knowledge of the CAM therapies potentially available. While this may, in part at least, be due to the success of their participation in women's organisations courses, it may also signal that those women who were more isolated during their menopause were possibly underrepresented in the study.

Notwithstanding these limitations, we argue that in the period since the 'scare' about the safety of HT, participants who deemed their menopausal symptoms to be severe appeared to be active in shaping their doctors' prescribing practices in relation to HT. The indication is that the pressure to prescribe HT is emanating from women whose quality of life is heavily compromised in view of the distressing symptoms, rather than from GPs. This finding lends some support to existing empirical evidence from the UK that proposes that patients are having an impact on their doctors' behaviour in the realm of drug prescribing (Schwartz *et al*, 1989; Bradley, 1991). However, unlike our research, these studies have relied on the position of physicians without exploring the patient's perspective. Although there is research to indicate that doctors maintain that they over-prescribe on the grounds of patients' expectations (Britten and Ukoumunne, 1997, Cockburn and Pit, 1997), there is also evidence that some patients are disgruntled with what they assert to be inordinate levels of prescribing by their doctors (Lupton *et al* 1991, Calnan, 1988, Britten, 1996). Our data suggest that in the period since the HT 'scare', the prescribing of HT was very much restricted by physicians. Thus, doctors themselves appear to be observing best practice guidelines and from participants' accounts seem to be cautious about prescribing HT, in view of the adverse trial results. The upshot is that both women and

doctors appear to be hesitant when it comes to HT. This poses a difficulty for doctors because there are few other therapeutic options available to them, apart from that of general lifestyle advice and talk therapy, with the latter tending to be problematic in view of the pressures normally on GPs' time.

For most women who had taken it either currently or in the past, HT worked quickly and effectively and thereby created a pragmatic appeal that superseded any holistic introspection (see Crossley 2003: 249-50). Crossley (2003) links the continued increase in bio-chemical remedies precisely to their capacity to palliate symptoms, and the speed and convenience of their administration.

. . . they may be the only practical solution that may be administered in a brief consultation, sandwiched between many others. . . This affords the bio-medical model practical dominance. Whatever 'new age' maps of the soul we are attracted to in our moments of reflection, we are increasingly drawn to bio-medicine in our moments of need. And our moments of need . . . are increasing (249-50).

While CAM therapies tended to be far more favourable to women across the sample than was HT, consistent with the finding of other studies, we found that a proportion of women accepted HT where they experienced symptoms as severe (Hunter et al 1987; Morris and Symonds 2004). Nonetheless, the caution evident among participants in our study reflects more negative attitudes towards HT, and a decrease in HT-use in recent years (Lindh-Åstrand *et al.* 2007; Hoffmann *et al.* 2005). The interest in using alternative therapies to relieve menopause symptoms mirrors the findings of other studies across Western societies (Brett & Keenan 2007; van der Sluijs *et al.* 2007; Daley *et al.* 2006).

Yet using HT did not tend to spell a conversion to biomedical advocacy, in spite of its effectiveness in moderating bodily distresses. Rather, most women taking HT

deliberated about when and how they would discontinue its use. Nor did its use tend to disturb their affiliation to a natural discourse; rather HT-use tended to retain the tentative status as temporary relief, and not a long-term panacea.

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### **Summary for Table of Contents**

This qualitative study exploring women's experiences in biomedical consultations for menopause symptoms in an Irish context, with a particular focus on HT, indicates shifts in the prescribing practices of doctors and how women themselves influence HT prescribing. In addition, those using HT tended to use it as a temporary relief.